NOVA Medical School / Faculdade de Ciências Médicas

Universidade NOVA de Lisboa

Mental health of the Palestinian refugee communities in Lebanon: Strategy for the National Institute for Social Care and Vocational Training for 2018-2021.

Master's dissertation in Mental Health Policy and Services

By

Nancy Najm

Supervised by:

Professor Graça Cardoso

2017

Mental health of the Palestinian refugee communities in Lebanon: Strategy for the National Institute for Social Care and Vocational Training for 2018-2021.

Abstract (English)

The mental health programme of the National Institution for Social Care and Vocational Training, serving the community of Palestinian refugees in Lebanon, requires a mental health strategy. This dissertation consists in such a strategy which contributes in reducing the burden of mental disorders in this community and thus improve the overall life quality of the community.

Method

The NISCVT appointed the author to facilitate the development process of the mental health strategy according to WHO's recommendations for policy and services development. The development of the strategy is grounded in interviews conducted by the author with key persons in the NISCVT. It unfolds in five steps:

- Consultations with stakeholders.
- Situation analysis of the current programme.
- The elaboration of the policy elements: vision, mission, objectives, values, guiding principles.
- Development of a first draft of the strategy.
- Experts reviews.

Results

A mental health strategy for the NISCVT was developed following a consultational process. Five domains of action are identified: (1) Leadership and Governance, (2) Re-orientation and Scaling-up of Services, (3) Prevention and Promotion, (4) Information, Evidence and Research and (5) Vulnerable Groups. Each domain comprises of a general goal, strategic objectives and targets for the achievement of the objectives.

Conclusion

This dissertation describes a successful collaboration among key stakeholders of the mental health programme of NISCVT which resulted in the development of a strategic policy. It is recommended to complete the development process of the strategy in these five steps: (1) an elaboration of a second draft following the experts review, (2) building a consensus among all the stakeholders, (3) an elaboration of final draft and an (4) online launching. Also, (5) an implementation plan needs to be developed to lay out a roadmap for delivering the commitments and recommendations of the mental health strategy.

Keywords: Mental Health, Palestinian refugees, Programme, Strategy, NISCVT.

Resumo (Português)

O programa de saúde mental do National Institution for Social Care and Vocational Training, que presta cuidados à comunidade de refugiados palestinianos no Líbano, exige uma estratégia de saúde mental. Esta dissertação consiste na descrição dessa estratégia, que vai contribuir para reduzir a carga de perturbações mentais nesta comunidade e, desse modo, melhorar a qualidade de vida geral da comunidade.

Métodos

O NISCVT nomeou a autora da tese para facilitar o processo de desenvolvimento da estratégia de saúde mental de acordo com as recomendações da OMS para o desenvolvimento de políticas e serviços. O desenvolvimento da estratégia baseia-se em entrevistas realizadas pela autora com pessoas-chave no NISCVT e desdobra-se em cinco etapas:

- Consultas com as partes interessadas.
- Análise da situação do programa atual.
- Elaboração dos elementos políticos: visão, missão, objetivos, valores e princípios orientadores.
- Desenvolvimento de um primeiro rascunho da estratégia.
- Revisões por especialistas.

Resultados

Uma estratégia de saúde mental para o NISCVT foi desenvolvida após um processo de consulta. São identificados cinco domínios de ação: (1) Liderança e Governança, (2) Reorientação e Ampliação de Serviços, (3) Prevenção e Promoção, (4) Informações, Evidências e Pesquisa e (5) Grupos Vulneráveis. Cada domínio compreende um objetivo geral, objetivos estratégicos e metas para a consecução dos objetivos.

Conclusões

Esta dissertação descreve uma colaboração bem sucedida entre os principais interessados no programa de saúde mental do NISCVT, que resultou no desenvolvimento de uma política

estratégica. Recomenda-se concluir o processo de desenvolvimento da estratégia nestes cinco passos: (1) elaboração de um segundo rascunho na sequência da avaliação dos peritos, (2) elaboração de um consenso entre todas as partes interessadas, (3) elaboração de rascunho final e (4) lançamento online. Além disso, (5) precisa ser desenvolvido um plano de implementação para estabelecer um roteiro para a entrega dos compromissos e recomendações da estratégia de saúde mental.

Palavras-chave: Saúde Mental, Refugiados Palestinianos, Programa, Estratégia, NISCVT.

Resumén (Español)

El programa de salud mental del National Institution for Social Care and Vocational Training, que presta asistencia a la comunidad de refugiados palestinos en el Líbano, exige una estrategia de salud mental. Esta disertación consiste en la descripción de esta estrategia, que contribuirá a reducir la carga de perturbaciones mentales en esta comunidad y, de este modo, a mejorar la calidad de vida general de la comunidad.

Métodos

El NISCVT nombró a la autora de la tesis para facilitar el proceso de desarrollo de la estrategia de salud mental de acuerdo con las recomendaciones de la OMS para el desarrollo de políticas y servicios. El desarrollo de la estrategia se basa en entrevistas realizadas por la autora con personas clave en el NISCVT y se desdobla en cinco etapas:

- Consultas con las partes interesadas.
- Análisis de la situación del programa actual.
- Elaboración de los elementos políticos: visión, misión, objetivos, valores y principios rectores.
- Desarrollo de un primer borrador de la estrategia.
- Revisión por expertos.

Resultados

Una estrategia de salud mental para el NISCVT se desarrolló tras un proceso de consulta. Se identifican cinco áreas de acción: (1) Liderazgo y Gobernabilidad, (2) Reorientación y servicios de expansión (3) Prevención y Promoción, (4) Información, Pruebas y (5) grupos vulnerables Investigación. Cada dominio comprende un objetivo general, objetivos estratégicos y metas para la consecución de los objetivos.

Conclusiones

Esta disertación describe una colaboración exitosa entre los principales interesados en el programa de salud mental del NISCVT, que resultó en el desarrollo de una política estratégica. Se recomienda para completar el proceso de desarrollo estratégico en estos cinco pasos: (1) preparar un segundo borrador después de la evaluación de los expertos, (2) el desarrollo de un consenso entre todas las partes interesadas, (3) la preparación del proyecto final y (4) lanzamiento en línea. Además, (5) debe desarrollarse un plan de aplicación para establecer un itinerario para la entrega de los compromisos y recomendaciones de la estrategia de salud mental.

Palabras clave: Salud Mental, Refugiados Palestinos, Programa, Estrategia, NISCVT.

Acknowledgments

The present dissertation is to be implemented as the mental health strategy for NISCVT thanks to several people and institutions.

First of all, I would like to thank Prof. Dr. Graça Cardoso who carefully supervised the writing of this dissertation. Also, this study has been much enriched by the inputs I received during my two years of Master studies at NOVA Medical School from Professors in charge of curricular units: Benedetto Saraceno, Graça Cardoso, José Miguel Caldas de Almeida, Miguel Xavier and Gonçalves Perreira.

As well, the development of this strategy would not have been possible without the professional collaboration and dedicated support of several colleagues from and users of the NISCVT: Mr. Kassem Aina (General Director), Ms. Muna Khalidi (member of the board of directors), Dr. Madeleine Taha (Senior child psychiatrist), Ms. Liliane Younes (mental health programme coordinator) and Ms Khawla Khalaf (director of El Buss center).

I would like to particularly thank Dr. Rabih El Chammay who first inspired me towards this undertaking. Together with his colleagues from the Ministry of Health among whom I mention Ms Jinane Abi Ramia and Ms Perrine Posbic they informed me about the critical aspects and needs that the implementation of such a strategy requires in the Lebanese context.

I also thank my colleagues from the Kaunas University of Technology, especially Saule Petroniene, for their support. My collaboration with them led to an enrichment of my understanding in Linguistic, cultural and communication phenomena which are very relevant for the subject of this dissertation.

Finally, I must express my very profound gratitude to my lovely husband Alin and to my beloved family for providing me with continuous encouragement throughout my years of study. This accomplishment would not have been possible without them.

Table of Contents

List of Tables and Figures

Tables

Figures

Acronyms

AIMS	Assessment Instrument for Mental Health Systems
BAS	Beit Atfal Assumud
EMRO	Eastern Mediterranean regional office
FGC	Family Guidance Center
GP	General Practitioners
HI	Handicap International
HIS	Health Information System
ICARE	Institute for Care Assessment and Research
IMC	International Medical Corps
MHGAP	Mental Health Gap Action Programme
MHPSS	Mental Health Psycho Social Support
MSF	Médecins Sans Frontières
MOPH	Ministry of Public Health
NISCVT	National Institute for Social Care and Vocational Training
PHC	Primary Health Care
SOP	Standard Operating procedures
SWOT	Strengths Weaknesses Opportunities and Threats
UN	United Nations
UNRWA	United Nations Relief and Works Agency
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

1. Introduction

The mental health programme of the National Institute for Social Care and Vocational Training (NISCVT) was established in 1996 in Lebanon to address the growing mental health needs of the community of Palestinian refugees, especially of children and adolescents, living in Lebanon. This dissertation consists in the first draft of a community-based mental health strategy for the NISCVT. The purpose of this strategy is that this institution reaches out to a larger number of users, given the limited resource and growing need. This strategy is developed in the context of a six-year ongoing civil war in Syria which resulted in Lebanon's receiving of a large number of Palestinian refugees from Syria. The refugee communities in Lebanon are witnessing an accelerated growth. A vast population affected by war and violence seek asylum. The already settled refugee population is not properly integrated in the Lebanese society and, thus, it faces discrimination and socio-economic distress. The refugee population is vulnerable, disfavored and in need of mental health services. Therefore, given the limited existing resources in Lebanon, a geographically small territory, with its own political unrest, the outreach of these services needs to extend, keeping up with the growing vulnerable refugee population and its needs. Given the situation, the process of extending the outreach of mental health services has not been occurring efficiently enough. The institutions concerned to extend their services are in a trial stage still. As such, the NISCVT needs to be prepared to serve professionally a large and vulnerable refugee population.

Running mainly on funds from international donors, the mental health programme of the NISCVT was intended to run for two years only, with one mental health team covering the needs of Palestinian refugees in the capital (Beirut). The programme managed not only to sustain its services for twenty-one years after its launching but also to grow geographically, to build more mental health teams, to include a larger variety of preventive and curative services, to become a resource center for other actors in the community and to serve a higher number of families. As a result, there was an increased awareness on mental health issues amongst this population which led to an elevated demand on services and long waiting lists. All these issues were coupled with

the NGO's financial insecurity as the funding was available only in short term chunks, with poor coordination and a lack of consensus among key stakeholders (such as, for instance on the model of care to be adopted by all teams). To address these challenges, the NISCVT decided to invest in effective and evidence-based care through the development of a strategic policy which would provide strategic directions to improve the mental health care of its programme.

The author was appointed by the NISCVT to develop such a strategy, given her experience of working with the institution during the past seven years. During this time, the author worked, directly with the refugee population, as a speech therapist and a trainer of local community mental health workers. This led to the author having had developed a pioneering task-shifting model by training community workers to deliver home-based speech therapy services and training for parents so that a larger number of children could be treated. Given the author's direct experience of working with this refugee population, within the NISCVT, she was appointed to develop a community-based mental health strategy. Her inside experience was essential for the task. Throughout the writing of this strategy, the author has been receiving the support of the NISCVT, facilitating access to all the necessary documents and resources. The institution also created a steering committee for this purpose. The committee kept the author informed about the situation on the territory.

2. Literature review

2.1 Global overview on mental health

Mental health is an integral part of health and is defined as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO 2004, p. XVIII). Mental health constitutes a major public health concern worldwide. Mental disorders are highly prevalent in high and low-income countries and are thus considered as the leading cause of ill-health and disability (Demyttenaere et al., 2004). Mental health problems affect one in five people globally, with depression reported to be the leading cause of global burden of disease (Steel et al. 2014 p. 488, Ferrari et al. 2013 p. 6). They account for 1833.9 million disability-adjusted-life-years (DALYS) as per the Global Burden of Disease (GBD) study in 2010. Mental and substance use disorders have substantially increased recently and represent the 4th out of 10 leading causes of the disability worldwide; this increase has been significantly correlated with the epidemiological shift from communicable to the non-communicable diseases over the past decades (WHO 2001).

The development of mental health conditions is thought to be caused by the interaction of many factors: biological, psychological and social (WHO 2001, p.4). These factors could be poverty, sex, age, conflict and disasters, major physical diseases, family relationships and social environment (WHO 2003).

The widespread mental disorders have consequences not only on the quality of life of the individuals with such conditions and their close family, but also affect society and economy at a larger scale (WHO 2003). Mental disorders have a strong impact on the individual's functioning, resulting in a high-level disability and impairment. Disabilities can be observed in the affected individuals' home management, ability to work, social life and ability to maintain relationships with family and friends (Alonso et al. p. 232). Briefly, mental disorders are associated with productivity loss (WHO 2003). As such, the rise of percentages of YLD and DALY in a society has a substantial effect on the society's economy.

In light of recent research (WHO 2015, p. 8), progress has been made in the development of mental health policies and services whereby more countries developed mental health policies and action plans; in fact, in 2014, 68% of all WHO member states already had a mental health policy. In addition, among the 37 countries that did not have a mental health policy/plan, 21 integrated mental health policies/plans into their general health policy (WHO 2014). Also, the evidence on sociopolitical and economic determinants of health encourages decision makers to integrate mental health in general health policies and to develop it in collaboration with other sectors, such as justice, education, social welfare and housing (Herrman et al. 2005 p. 55). However, despite these improvements, at a global level, many hindrances to the access of the population to appropriate care and treatment persist. Lack of knowledge about mental disorders, delays in starting treatment, stigma, the high cost of services, and the limited or unavailable services are the basic reasons for the mismatch between the need and the access to services (Kohn et al. 2004). Due to this treatment gap, as termed in the 2001 World Health Report (p. 3), the magnitude of the burden of mental disorders continues to increase. Patel et al. (2010) indicated three strategies to reduce the treatment gap which exceeds 50% in all countries. The strategies suggested are: "increasing the numbers of psychiatrists and other mental health professionals; increasing the involvement of a range of appropriately trained non-specialist providers; and the active involvement of people affected by mental disorders" (p. 175). According to this study, task-shifting to non-specialist health workers under specialists' supervision is a cost-effective strategy that meliorates the results of treating people with mental disorders. For these reasons, it is urgent to prioritize the development and improvement of mental health systems.

2.2 Development and improvement of mental health systems

To address mental health needs of the population at a global scale, the WHO positioned mental health issues within the global public health priorities. It attempted to do so over the last decades by switching the perception of mental disorders being isolated from physical health into a perception where mental and physical health have a reciprocal interaction. Also, many efforts were invested in providing evidence of the effectiveness of various treatments for mental disorders

which contributed to a worldwide mental health reform. In 2001, the WHO introduced the *World health report 2001* (WHO 2001). This is considered a landmark report because it pioneered the aims of increasing the understanding of mental disorders and of spreading knowledge about the burden of mental disorders and trends in care and treatment. This report provides countries with ten overall recommendations to reform their mental health system and actions for each recommendation. The actions vary depending on the level of resources in a country (low, medium or high). The recommendations comprise the following:

"- Provide treatment in primary care.
- Make psychotropic medicines available.
- Give care in the community.
- Educate the public.
- Involve communities, families and consumers.
- Establish national policies, programmes and legislation.
- Develop human resources.
- Link with other sectors.
- Monitor community mental health.
- Support more research". (WHO., 2001. p. 110-114)

Along the lines of WHO's *World Health Report*'s recommendations, a *Balanced Model of Care* was conceptualized (Thornicroft, G. and Tansella, M., 2004). It considers both community-based and hospital-based services necessary. This model proposes an integrated approach which includes both services. Given the role that a country's resources play in the design and the implementation of a mental health plan, it was necessary for the balanced model of care to propose mental health services components in three versions which are relevant to (1) low-, (2) medium- and (3) high-income countries. The key services for each resource setting are summarized in figure 1. A positive aspect of this model is that it can be applied on both a national and on rather local level, such as different sectors or programmes with different resources within one country.

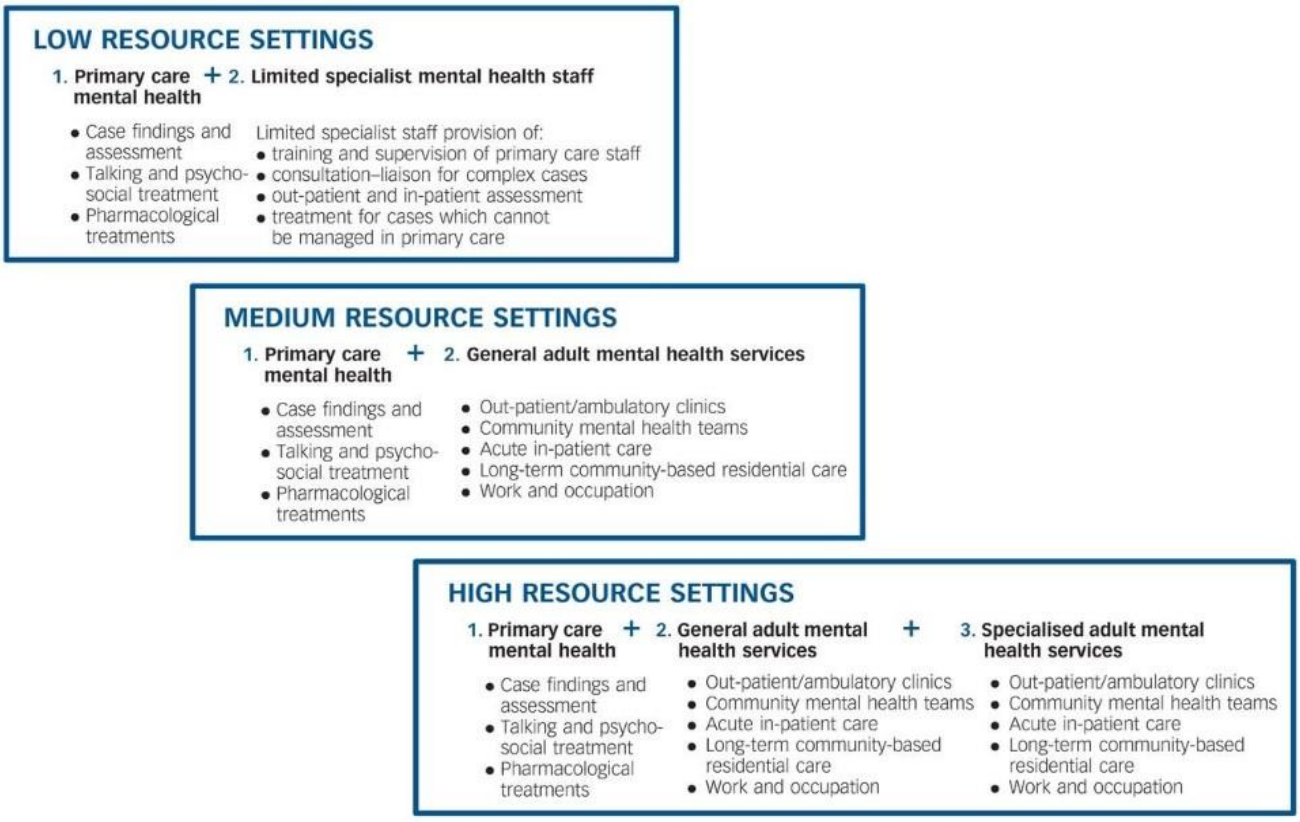

Figure 1: "Mental health service components relevant to low, medium and high resource settings" Source: Thornicroft and Tansella 2013, p. 247

In the scope of this dissertation, this model will be used as a reference at a later stage, to reflect on and conceptualize the most appropriate mix of mental health services in a low-income resource setting: the Palestinian refugees' communities living in Lebanon.

On a Policy level, mental health reform could not have taken place without the development of supportive government policies, actions and programmes. On this level, the WHO strived to support policy-makers and service planners worldwide to develop mental health policies in their countries through its *Mental Health Policy and Service Guidance Package*. This package comprises various however inter-related modules which cover all the core components of mental health policies. The package is meant to be comprehensive and to address all the needs of policy development and service planning (WHO 2003, p. x). It offers therefore practical information on:

policy development, designing plans and programmes, financing, legislation and human rights, quality improvement, organization of services, planning and budgeting, advocacy, research and evaluation, information systems, child and adolescent mental health policies and plans, human resources and training, access and use of psychotropic medicines, mental health policies and plans in the workplace (WHO 2003, p.11).

In 2008 the WHO developed the mental health gap action programme (mhGAP) (WHO 2008). The mhGAP is an intervention guide that aims at expanding services for mental, neurological and substance abuse disorders in low and non-specialized resource settings. Such a programme was needed because of the increasing treatment gap, especially in low- and middle-income countries due to ineffective response from national health systems (scarcity of resources, poor quality of care, low financial allocations to community-based services) (WHO 2013, p. 8). As such, mental health care systems needed to be strengthened and improved. The mhGAP was followed and build on by a comprehensive mental health action plan in 2013: *Mental Health Action Plan 2013-2020* (WHO 2013). The action plan offers a more global scope which provides guidance to national action plans. It was elaborated in consultation with member states, civil society and international partners. The action plan's vision, goal and objectives (see table 1) are of high importance for the development of mental health care systems in countries, like Lebanon (the country where this paper is developed and will be implemented). The Lebanese ministry of health developed its mental health system in line with WHO's mental health action plan. (Ministry of Public Health 2015, p. 13).

Vision	"The vision of the action plan is a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination ."
Goal	"[…]to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders."
Objectives	"1. to strengthen effective leadership and governance for mental health; 2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings; 3. To implement strategies for promotion and prevention in mental health; 4. to strengthen information systems, evidence and research for mental health"

Table 1. Vision, goal and objectives of the Mental Health Action Plan 2013-2020

Source: WHO 2013, p. 9-10

The next section consists in an overview of the Lebanese mental health system's history and development. The purpose is to provide a clear understanding of the context of the development of the present study.

2.3 The context of Lebanon

2.3.1 Mental health in Lebanon

Lebanon is a middle-income country, inflicted by wars, conflicts and political turmoil in its recent history. The country's situation renders the population susceptible to mental health disorders (Karam et al., 2008). In Lebanon, studies have shown that 1 in 4 individuals suffer from a mental health disorder throughout their lives whereas only 1 in 9 actually receive treatment (Karam et al., 2008). Delaying care is a common habit in the Lebanese community whereby people tend to delay their care seeking behavior for around 6 years, especially for mood disorders such as depression, and to 28 years for anxiety disorders. This leads to their conditions becoming recurrent and chronic (Karam et al., 2008). According to the Institute for Health Metrics and Evaluation Global Burden of Disease Study, estimations of yearly morbidity show that nearly 152 individuals in Lebanon die every year due to a mental disorder or through suicide (Institute for Health Metrics and Evaluation, 2013).

Despite the crucial need for mental health care in Lebanon, the access to affordable and adequate mental health services is still limited. The primordial factors hindering the access to care are financial difficulties, stigma and lack of awareness. There is a significant shortage of human resources such as psychiatrists, nurses, and psychologists; there are 1.26 psychiatrists per 100,000 population and 3.42 psychologists per 100,000 population from which 97% of the mental health care workforce work in private practice in Lebanon (Republic of Lebanon Ministry of Public Health 2015 & WHO-AIMS, 2015). As such, the mental health system is mostly privately maximized while the public sector remains underdeveloped thus limiting the access to adequate services for the general public. Given the situation, until 2015 there was a lack of mental health

training for primary health care workers. Interactions between the primary care and mental health system were rare since the care model emphasizes the curative approach in the secondary and tertiary levels.

The services in place mainly consist of treating patients in psychiatric hospitals, and providing psychotropic medications for out-patients who do not benefit from a health coverage plan (Kerbage, El Chammay and Richa, 2013).

According to WHO-AIMS report in 2015 (WHO and Ministry of Health Lebanon, 2015), there are 5 mental hospitals that hold 88% of total psychiatric beds, while the remaining are divided among community residential facilities and inpatient units (community-based and forensic). There are only 8 psychiatric wards in general hospitals. As a result, a high proportion of people with mental disorders are left without care and outpatient users seek care in the expensive private sector. Additionally, the strain on the health system has been recently intensified especially with the sudden increase by 1/3 of the population in 2013 due to the influx of displaced Syrians, as a consequence of the war in Syria. Since then, the NGO sector has been very active in supporting and compensating for this scarcity (WHO and MOPH, 2015, p. 26)

The existing research offers a comprehensive insight into the situation of mental health in Lebanon. The burden of mental disorders in this country is very high. The health system's efficiency must be improved to integrate mental health into primary care, increase coverage and reduce out of pocket spending.

2.3.2 Summary of the Mental Health strategy for Lebanon 2015-2020

In light of the urgent need for services coupled with a scarcity in the resources and the overstretched system, the public sector started to progressively regain its control over services and the Ministry of Public Health (MoPH) aimed at reforming and strengthening the already existing mental health services through prevention, promotion and treatment in order to secure a universal coverage of mental health services in Lebanon.

In 2014, the National Mental Health Programme (NMHP) was launched in Lebanon by the Ministry of Public Health (Ministry of Public Health, 2014). The programme started off by unifying the concept, goals and strategies for the mental health in Lebanon among all actors from the public and private sectors, the UN agencies, and the civil society organizations. In 2015, the programme launched a mental health and substance use prevention, promotion and treatment strategy in collaboration with WHO, UNICEF and IMC (Ministry of Public Health 2015, p. 9). The aim of the national mental health strategy is to reform the mental health system for all persons living in Lebanon. The strategy comprises 5 domains of action that are in line with the WHO Global Action plan for mental health (2013-2020) (Ministry of Public Health 2015, p. 13).

In the domain of Leadership and Governance, the programme launched an inter-ministerial substance use strategy joint between 5 different ministries: the ministry of education and higher education, ministry of interior, justice, social affairs and health. In line with this strategy, the team is revisiting the existing laws related to mental health and substance use.

The programme formed a task force called Mental health psycho-social support (MHPSS) that includes around 60 different organizations that aim to coordinate and harmonize the work and humanitarian response for the Syrian crisis in the mental health and psychosocial support to increase access to care.

In the second domain of reorientation and scaling up of mental health services, the NMHP is focusing efforts in the integration of mental health in the primary health care sector with the aim to increase prevention, promotion and early detection of mental cases. This is being done through the forming of community-based mental health centres with multidisciplinary teams in several regions across Lebanon. Also, the MoPH developed accreditation standards for the mental health services in primary health care centers, community centers and hospitals to ensure excellence in the quality of services delivered. In addition, a common list of psychotropic medications was developed so as to ensure a continuous and timely access to medications at all levels of care. In parallel, in order to increase the capacity of services at the hospital level, the MoPH increased the number of beds in psychiatric wards in several hospitals. NMHP is addressing the shortage of skilled human resources by building the capacity and training more than 2000 workers in the health

and protection sectors. Also, the Mental Health Gap Action Programme (MHGAP), developed by the WHO, was adapted to the Lebanese context through workshops. Specialized health care professionals were trained on how to provide training on the MHGAP to non-specialized primary health care staff (medical doctors, nurses and social workers from 31 centers across Lebanon). The advanced training evolved around identifying, managing, and referring mental health cases.

In the third domain of promotion and prevention the MoPH is conducting yearly national campaigns on mental health in collaboration with other ministries and UN agencies. Furthermore, it aimed at integrating mental health into the educational programmes and curricula; as such, the NMHP is closely collaborating with the Ministry of Social Affairs (MoSA), the Ministry of Education and Higher Education (MEHE) and universities to mainstream mental health in their educational and awareness programmes.

In the fourth domain of action which is related to information, evidence and research, the NMHP is designing electronic systems to map the existing services and thus be able to monitor the quality and type of services provided which will guide further decisions and development plans. A National Drug Observatory was established to guide substance use response.

The final domain is related to vulnerable groups in Lebanon. In this sector, the MoPH is collaborating closely with the prisons' health committee and is working on a mental health and substance use strategy tailored for the needs of the prisoners. Also, a formal collaboration was initiated between MoPH and UNRWA to provide technical support and mainstream mental health for Palestinian refugees in Lebanon.

These efforts and plans, implemented in a collaborative and transparent way, are reshaping the mental health system in Lebanon.

2.4 Palestinian refugees in Lebanon

2.4.1 Overview of the Palestinian refugees in Lebanon

According to the UN estimates in 1950, around 800 thousand Palestinians were displaced to the neighboring countries during the 1948 Arab-Israeli war (United Nations 1951). This led to the setting of temporary camps in Lebanon, Syria and Jordan to provide shelter for the Palestinians. A UN organization (the United Nations Relief and Works Agency, UNRWA) was created in May 1950 (United Nation, 1951) to assist the displaced Palestinians. Until this date, in the absence of a solution for the Palestinian state, UNRWA remains their main service provider in the areas of health, education, relief and social services, infrastructure and camp improvement, microfinance and emergency response (UNRWA, 2017).

According to the data of UNRWA, Palestinian refugees registered in Lebanon represent 10% of the population and 8.9% of the total number of Palestinian refugees in the near east (UNRWA and PCBS, 2015). About 62% of them live in the country's 12 camps and 38% in gatherings (Chaaban et al., 2010, p. x). The camps are distributed in the main Lebanese governorates. There are 2 camps in the North, 3 camps in Beirut, 5 camps in the South, 1 camp in the Bekaa and 1 camp in the eastern suburb of Beirut. The gatherings are considered informal or unofficial camps, being spread throughout Lebanon (see figure 2).

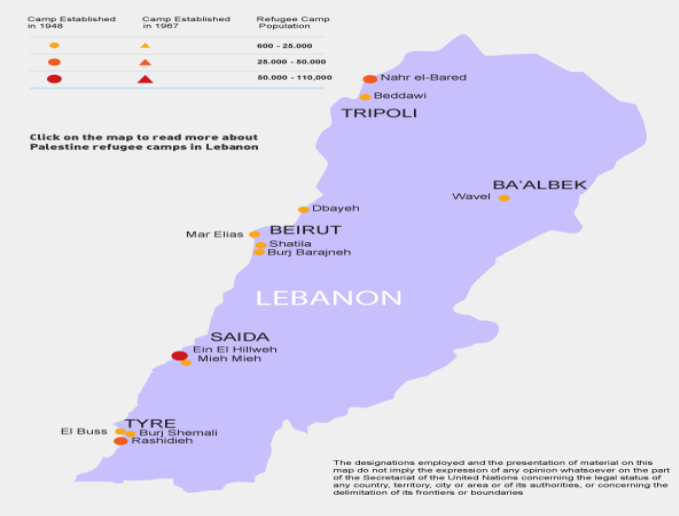

Figure 2. The distribution of Palestinian camps in Lebanon Source: UNRWA, 2017

Since the outbreak of the Syrian crisis in 2011, Lebanon begot the highest concentration of refugees per-capita worldwide. Currently, one out of four persons living in Lebanon is a refugee (European Commission, 2017). The UN high commission for refugees estimated that the number of Syrian refugees in 2015 was 1,835,840 (UNHCR, 2015). A recent report issued by the Humanitarian Aid and Civil Protection department of the European Commission in October 2015, estimates the presence of 40,000 Palestinians from Syria (PRS), and 17,000 Iraqis in Lebanon. In result of this long-lasting influx, which accelerated recently, the economy and infrastructure is under a heavy strain. This affects the quality and the accessibility of services to the refugee community and creates competition and tension with the Lebanese community.

Lebanon did not sign the UN convention relating to the status of refugees in 1951 or its 1967 protocol nor has it enacted any specific legislation targeting the issue of refugees. As a result, Palestinian refugees, considered as stateless refugees by the Lebanese government, do not enjoy basic civil rights and they do not have citizenship (ILO 2012, p. 21). They are subject to discriminatory laws and practices, mainly in the fields of employment, education, housing and health. The Lebanese governments barely amended these laws, fearing that such revisions might pave the way for permanent settlement. (ILO 2012 p.20). This creates serious obstacles for the development of the Palestinian community in Lebanon and further worsened the harsh living

conditions of Palestinians in Lebanon. This was mainly intensified due to restrictions on Palestinians in integrating in the labor market (Chaaban et al. 2015 & ILO, 2012). For instance, Palestinians are employed in low-status jobs, on a daily or weekly basis. This implies that the majority do not have working contracts. Few are entitled to health coverage, sick leaves, holidays, family and end of services indemnities. The majority are poorly paid, overworked and live in poor housing conditions with a limited access to quality services and social protection (ILO 2012). They also face restricted access to many liberal and syndicate professions (Chaaban et al., 2015). Besides, they are denied the right to own property (ILO, 2012 & Chaaban et al., 2015). By not being allowed to invest in a property or a business, the Palestinians' socio-economic possibilities are very limited. In comparison to PRL, PRS have a higher level of poverty as they come across fewer work opportunities. They show a higher rate of school non-attendance because of financial, health and security reasons. The majority is reported to live in fear of being deported by the Lebanese government who imposes strict restrictions on them.

According to Chaaban et al. (2015) education is a buffer that alleviates poverty level among the Palestinian refugee communities. Higher education attainment was also linked to better health outcomes. However, the figures show that only 11.9% of PRL over the age of 25 have a baccalaureate (A level) degree and only 6.2% have a university degree, with the level of illiteracy among females almost double then among males. Many children with disabilities are excluded from the educational system. High levels of chronic and acute illnesses as well as functional disabilities were also observed. 37% of the PRL are reported to have a chronic illness. The most common conditions described are hypertension, chronic pulmonary diseases (which include asthma), diabetes and cardiovascular diseases. Many of the educational and health needs of the Palestinian communities are unmet also because of the cuts on UNRWA's budget. In efforts to bridge the gap, international agencies, institutions, non-government organizations and local community-based organizations provide complimentary basic services. These services range from housing repair, health care, health education, social services, vocational training programmes, early childhood development programmes, employment opportunities and women empowerment programmes. (Anera 2012).

2.4.2 Mental health of the Palestinian refugees in Lebanon.

Mental health issues within the Palestinian community in Lebanon are very common (Habib et al., 2004). Research on Palestinian communities in Lebanon shows a strong correlation between disability and poverty (Al-Madi et al. 2003, Zabaneh et al. 2008, Habib et al. 2014) and a higher co-occurrence of mental and physical conditions associated with socioeconomic deprivation (Habib et al., 2014).

In 2004, 52% of Palestinians suffered from a chronic illness, 30% had an acute illness in the past 6 months and 57% reported poor mental health (Habib et al., 2004). In 2015, over half of PRL (51.3%) and 85% of PRS reported having poor mental health in a self-rated mental health survey (Chaaban et al., 2015).

A smaller-scale study, conducted by Médecins sans frontières (MSF) and the Lebanese American University in 2011 found that 29% of the inhabitants of a Palestinian refugee camp in Beirut were reported to have at least one mental health disorder with depression being the most common mental disorder (MSF 2011). It was also shown that 96% of people with a diagnosis of mental health disorder or with a need of psychological or psychiatric support did not have appropriate access to mental health services. The high levels of unmet needs were associated with 2 factors despite free and well-promoted health care in the camp. On one hand, the study reported a meaningful discordance between clinician diagnosis and self-perceived need for care. On the other hand, a high stigma surrounding mental disorders in the camp was recognized (Llosa et al., 2010).

2.4.3 Mental health of Palestinian children and youth in Lebanon.

No comprehensive study on the young Palestinian population's mental health has been yet conducted. Nevertheless, an assessment survey published by ICARE and HI in 2009 uncovered striking results among Palestinian children and adolescents. The survey showed that the majority of children (63.7%) were diagnosed with at least one mental health disorder and 34.1% were diagnosed with comorbid mental disorders. Anxiety and mood disorders as well as disruptive

disorders were found to be the most common. The assessment survey also explored the availability of mental health services. The report highlighted the following barriers to accessing mental health services: insufficient collaboration between organizations, shortage of mental health professionals, a lack of awareness among parents, financial difficulties, stigma of mental illness, and eagerness to obtain fast and tangible results (Husseini et al., 2010).

The Lebanese government recently made efforts to improve the situation of this vulnerable group. However, the community's needs are not satisfactorily met. The implementation of a mental health strategy would help serve and respond better to this community's needs, without an additional use of resources. Several organizations such as the National Institute of Social Care and Vocational Training (NISCVT) are working on improving the Palestinian refugee community's situation. NISCVT, through their mental health programmes are striving to alleviate the existent treatment gap through the provision of both psychological and psychiatric therapy for mental health related conditions as well as rehabilitation therapy for physical disabilities affecting Palestinian children.

2.4.4 Mental health programme of the NISCVT.

2.4.4.1 Introduction

Mental health services for Palestinian children and adolescents in Lebanon are the enterprise of several organizations, among which the most comprehensive take place at the Family Guidance Centre (FGC) of the Lebanese-Palestinian NGO National Institute for Social Care and Vocational Training (NISCVT) or as commonly known Beit Atfal Assumud (BAS).

The NISCVT addresses several issues concerning the welfare of Palestinian refugees, focusing on education, social development, health and relief. This NGO is in place since 1976 and it is a non-sectarian, non-religious and non-political institute. Its organizational structure (see figure 3) shows a variety of formal and informal services in the areas where there is a high concentration of Palestinian refugees.

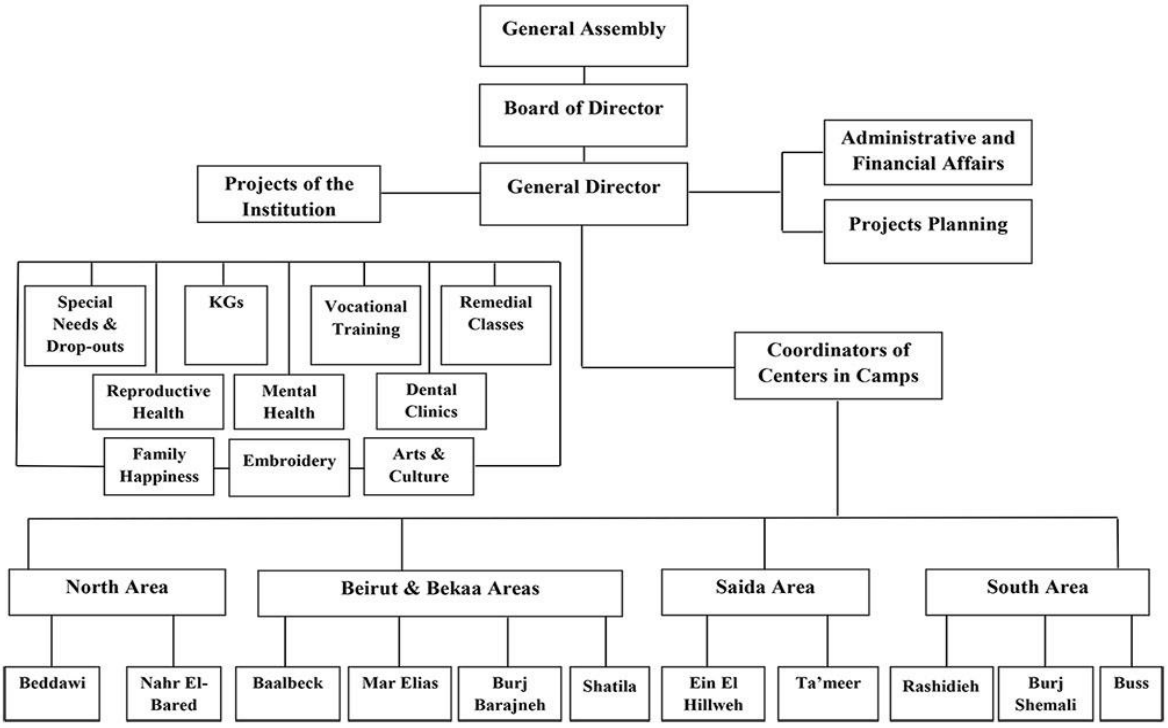

Figure 3. The organizational structure of the NISCVT. Source: NISCVT, 2016

In the perspective of its mission, this organization offers various programmes among which the mental health care programme that facilitates the communication between the parents, their children and the community. As such, it works with children and their families, as well as the organizations, schools, kindergartens and the community within their environment, contributing to the wellbeing of children and their parents (see figure 4). The mental health programme is focused on prevention and treatment services for children and adolescents facing specific developmental, behavioral or emotional difficulties[1], counseling for parents and other caregivers and training for NGOs and teachers.

[1] The children and adolescents treated by the mental health programme of the NISCVT present disorders which comprise the following ICD-10 diagnosis:

- Mental retardation, F70-79.
- Disorders of psychological development, F80-89.
- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence, F90-98.
- Unspecified mental disorder, F99.

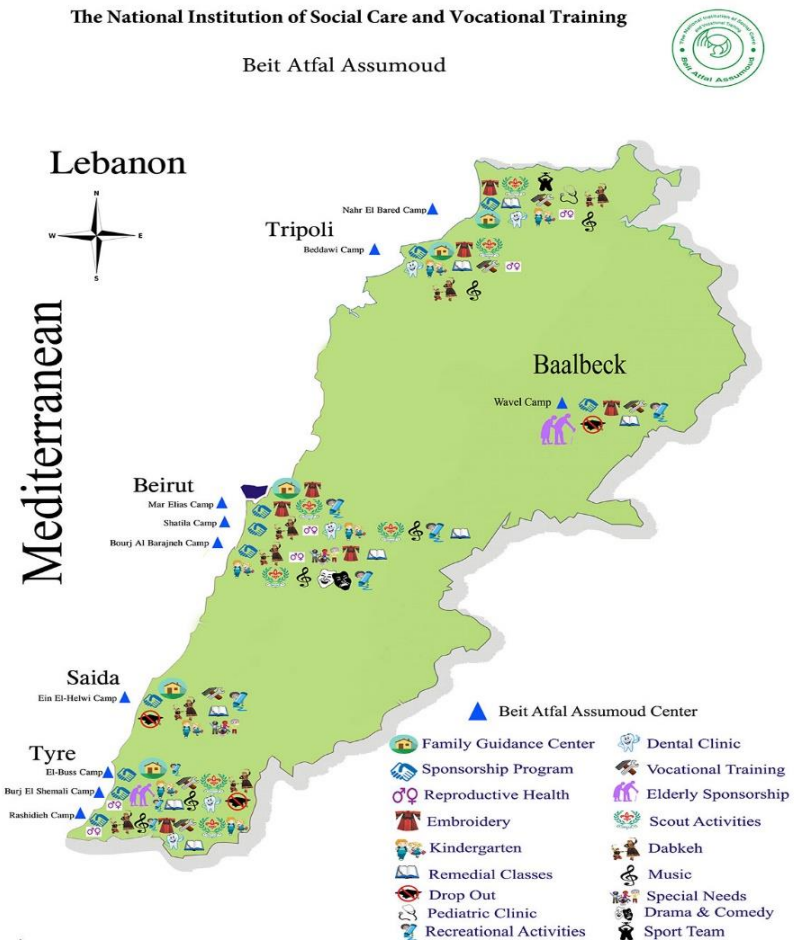

Figure 4. The distribution of the centers and the various programmes within Lebanon
Source: NISCVT, 2016.

In view of the components of mental health services (WHO 2003, p. 10), the services of the NISCVT fall under the category of formal community mental health services (see figure 5). Such services can be usually delivered through a range of different settings and levels of care. The mental health programme of the NISCVT offers Community-Based Rehabilitation services for special population. For instance, services for children and adolescents are delivered through outpatient clinics known as The Family Guidance Center (FGC).

The mental health services functions through multi-disciplinary teams, covering various areas: psychiatry, psychotherapy, psychological evaluations, speech therapy, occupational therapy, psychomotor therapy, special education, social intervention and music therapy. By doing so, the center also involves in its work caregivers from the Palestinian refugee community (mostly the children's family members).

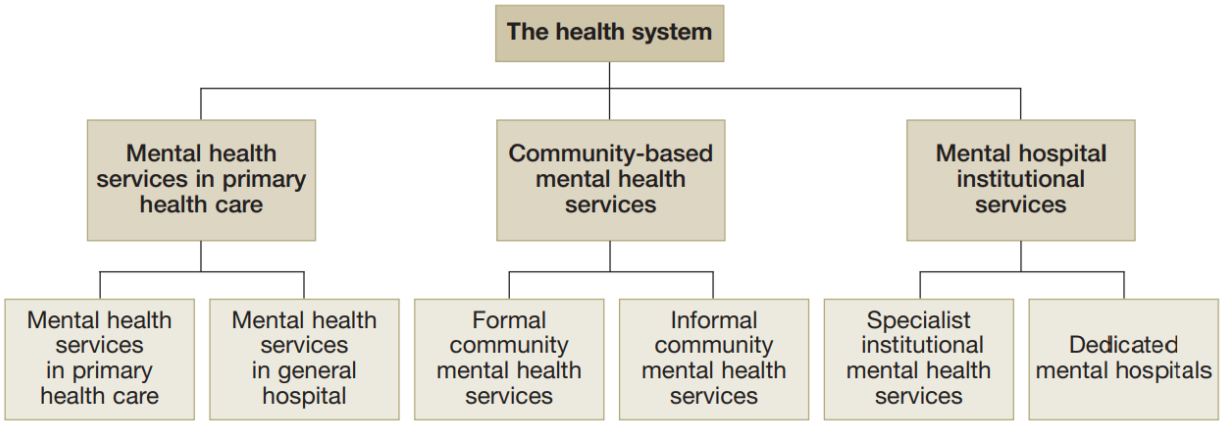

Figure 5: Components of mental health services.

Source: WHO 2003, p. 10

Currently five centers are offering mental health programmes among others in areas with a high concentration of Palestinian refugees: Beirut, El-Buss and Saida (Ta'ameer) in Southern Lebanon, and Beddawi and Nahr El-Bared camps in Northern Lebanon. The programmes were established as follows:

- FGC Beirut established in 1997
- FGC Beddawi established in 2005
- FGC Nahr EL Bared established in 2005
- FGC Al Buss established in 2007.
- FGC Saida established in 2010.

Since the institution was established, it developed strong relationship with various interested partners and funding agencies. The following is a list of supporters and funders of the mental health programme:

- NORWAC: the Norwegian Aid Committee.
- The Norwegian embassy
- The Finnish ministry of Foreign Affairs
- The Finnish Psychologists for Social Responsibility (FiPSR)
- The Finnish Arab Friendship Society (FAFS)
- Handicap International
- WELFARE association
- Santé Sud
- Agence Francaise pour le Developpement / AFD
- Children Campaign Palestine – CCP / Japan
- Prima Materia
- Palestinian Children - PalCh / Switzerland
- Christian Codrai Foundation- CCF / Italy.

2.4.4.2 Main principles of the programme

The mental health care programme of the NISCVT is concerned with extending its outreach and serving more refugees in need of mental health services. The programme attempts incessantly to meet its stated goals of providing low-cost psychological, emotional and educational guidance for children and their families, through the provision of specialized, high quality preventive and therapeutic services. Some teams adopt an individual-based approach, while others (e.g: the El-Buss team) are switching to a community based one. So far, in most areas covered by the programme, treatment sessions take place at the center. In parallel, a team of community workers provides outreach activities thus ensuring a link between the programme and the community. The teams work under the supervision of the psychiatrist and a coordinator is in charge of information dissemination and activities coordination within the centers. In 2016, a desk review and anecdotal

records on the most prevalent primary diagnoses (collected by Ms. Aziza Khalida (Phd), an external evaluator)[2] found that speech problems were the most widespread, followed by learning difficulties, intellectual disorder, depression and autism.

The programme relies entirely on international donors, who prefer to offer short-term funds, to finance its activities and services.

Despite the discrepancies between the different mental health teams in terms of approaches and services, there are nonetheless common guidelines and principles directing the services of all the teams in the different centers. The main ones are highlighted below:

Family Oriented Services

The involvement of the family is an integral and standard principle of the programme. It occurs on several levels depending on the nature of the difficulties. The mothers show usually a higher degree of involvement and attendance to the treatment sessions than the fathers who, due to cultural reasons, show more reluctance to take part in the treatment process. In terms of activities, several practices are implemented such as:

- Meetings between the families and the specialists to clarify their needs and to offer valuable information regarding the nature of the child's difficulties and about the main ways with which they can help him/her.
- Participation of the parents in the treatment sessions which are usually conducted by a specialist.
- Regular home visits during which the community workers offer support, guidance and practical modeling for parents.

[2] In 2016, the two Finnish NGOS: (1) the Finnish Psychologists for Social Responsibility (FiPSR)and (2) the Finnish Arab Friendship Society (FAFS), who support and fund many programmes of the NISCVT, hired Aziza Khalidi, PhD. ScD, to conduct an evaluation of the mental health services. The project is entitled: *Implementing Community Based Mental Health Framework at NISCVT/BAS FGCs in North and South Lebanon.* The NGO's permission to use the reports in this dissertation was obtained by the author. For more information about the report contact Ms Sirkku Kivisto, the NGOs' representative on sirkku.kivisto@gmail.com.

- Some teams offer specialized counselling and therapy to parents on an individual basis when needed.

Awareness Raising in the Community

The programme adopted and developed awareness raising activities as part of its package of services, with the aim to tackle stigma and to demystify mental health conditions. The activities undertaken include: lectures in the community, home visits, the holding of small discussion groups, lobbying with community leaders, and working through UNRWA and other NGOs and their existing networks of social workers. Some examples of the topics that were addressed are: drug abuse, learning disorders, sexual abuse, schizophrenia, child development and behavior. Evidence from desk reviews shows that as a result of these awareness raising activities, the number of children being brought to the centers for assistance increased, including the numbers of self-referred cases – indicating a heightened awareness among parents.

Early Detection and Referral

Another key principle of the mental health care programme is early detection and early referral for treatment. It relies on referrals from the NGO's extensive network of social workers and kindergarten teachers as well as other organizations from the community. Early detections and referrals are considered as main achievements, even though the internal referral system between the different programmes of the NISCVT is still not supported in clear and standardized procedures and policies.

Use of Medications in Treatment

Behavioral and educational interventions are prioritized over the use of psychiatric medications which are only prescribed in severe cases.

Training

Capacity building is a very important component of the programme. It combines theory and hands-on skill teaching and it has targeted over the past years: UNRWA nurses, primary healthcare medical staff, youth groups, Social Workers, and Teachers working agencies and NGOs.

Research

While research is not a main priority of the programme, it has nonetheless participated in some limited research when reliable and accurate data was available and it was mostly supported technically by international collaborators.

Annual Conference

The NISCVT has been organizing over the past years annual conferences on mental health to which many local, regional and international mental health stakeholders were invited. It resulted in giving to the programme a greater visibility and to the experts a good opportunity to share experiences and perspectives on mental health of the Palestinian refugees' community.

2.4.4.3 The experience of Al-Buss team:

The FGC Al-Buss is the organisation's third center. It serves the population of Palestinian refugees in the south of Lebanon, mainly in the governorate of Tyre. This highly populated, under-developed and war affected area[3] suffers from a scarcity of affordable, accessible and high quality mental health services. As such, the Al-Buss team struggles with limited human and financial resources, trying to answer the high demand for mental health services. In order to increase its

[3] In 2006, the war launched by Israel on Lebanon left the whole country and mainly the south suffering from a great human and economic loss (Darwish et al. 2009 p. 633).

outreach capacity this team started developing and implementing a pilot model which is based on evidence based approaches in low-middle income countries, namely task-shifting and home-based interventions. This model was technically and financially supported by Handicap International (HI), an international aid organization working in mental health and psycho-social support in Palestinian Camps since 2004. FGC Al-Buss and HI developed the mental health community based services from 2010 until 2016. This six-year project aimed at promoting and improving the mental health of children and their families in the community through awareness raising, networking, empowerment and care activities targeting at the same time the children and their families, as well as other community stakeholders working with children at schools, kindergartens and animation and social centers. As a result of this partnership, two important documents were produced in order to share the experiences developed among local and national stakeholders in the mental health field. The first document entitled *Community Based Mental Health: A practical methodological guide based on experiences of two multidisciplinary mental health teams in working with children and families in Palestinian camps,* represents a methodological guide on managerial activities, service provision practices and processes related to mental health promotion and care activities, while the second is a "lessons learned" document on parents' empowerment entitled : *Empowering Parents, a "lessons learnt" document on experiences in empowering parents of children with mental health problems in the Palestinian Camps by two multidisciplinary mental health teams*. Both papers[4] represent very important resources for the other mental health teams of the NISCVT as they document key approaches, practices and tools. Thus, the documents provide elements of good practices which aim to support professionals and managers in adapting their expertise to the specificity of a community based multidisciplinary provision of services to children living in marginalized or vulnerable communities.

[4] Handicap International (HI) is in the process of posting these two publications on their website. HI gave the author of this dissertation the permission to use the reports as reference. For more information on those publications, please contact Ms Sophia Maamari, HI's technical consultant, on smaamari@hi-me.org

A qualitative evaluation of these working models of the mental health programme at Al-Buss center, was conducted in 2012[5] involving the major stakeholders (therapists, social workers, and parents). The assessment showed the following results:

- "Community workers found the model stimulating as it added to their skill set.
- Parents found the model to be acceptable for them and their children.
- More children were enrolled in the programme from 130 children in 2010 to 190 children with in 2011 after task shifting.
- Parents gained skills to be able to assist their children on the long-term and became their children's main "specialist".
- Improvement of parent-child interaction.
- Faster generalization of skills by the child".

Despite its acknowledged positive results, these working models showed an important limitation, namely the increased workload of the community workers which was attributed the lack of a strategic policy to guide the project's implementation and to define clear roles and responsibilities. Nevertheless, this innovative experience helped the El-Buss team establish the foundation of a community based approach to treatment. As a result, other centers followed EL-Buss center's steps into shifting towards a community based model. To answer to this shift of approaches, community workers of the mental health teams underwent a training on the evidence based approach termed Community Based Rehabilitation (CBR).

A second evaluation of the mental health services followed, this time of the mental health programme in four centers (see footnote 6 in section 2.4.4.2). This assessment evaluated the implementation of this community based approach to treatment. The evaluation found that the four teams are applying several facets of the community based mental health model. Positive indicators

[5] Ms Zeina Hassan, a Master's student at the American University of Beirut (AUB) in 2012, was doing her practicum at Al-Buss center. Her practicum report *An Evaluation of a Community Based Approach: Integrating Task-Shifting and Home-Based Interventions as Working Models* is used as a reference in this dissertation, after obtaining the author's permission. For more information on the report, please contact Ms. Hassan on Zeinahassan@gmail.com.

of effectiveness and efficiency of the services among the different centers were highlighted. On the other hand, work load, staff turnover and financial sustainability were found to be the main challenges.

In order to organize, harmonize and consolidate the mental health programme across all the centers, both evaluation reports, cited previously, recommend the development of a strategic policy. The development of such a strategy represents the theme of this dissertation. In the following chapter, the methodology of its development as well as the main results are presented.

3. Study Design and Methodology

3.1 Objectives of the study:

The purpose of this study is to develop a mental health strategy for the mental health programme of the National Institute for Social Care and Vocational Training (NISCVT) 2018-2021. The users of this programme are mainly Palestinian children, adolescents and their caregivers, living as refugees in Lebanon. The strategy is designed to answer precisely to the specific needs of this vulnerable segment of the population.

3.2 Study design and method: the development process of NISCVT's mental health strategy:

In this section, key process steps of the development of NISCVT's mental health strategy are presented in detail (see figure 6). The process is in line with WHO's recommendations for policy and services development (WHO 2005). The first step consists in meeting with stakeholders from the programme to build consensus around the main points regarding the development of the policy. In the second step, a situation analysis is conducted and it entails: a literature review, a desk review and in-depth interviews with key informants. The data collected is organized in a SWOT (strengths, weaknesses, opportunities and threats) framework. The SWOT analysis provides the needed knowledge about the programme which leads to the next step, namely the elaboration of the strategy of the mental health programme of the NISCVT. Once the first draft is developed, the strategy is shared with stakeholders and experts for review. Finally, following the experts' input, improvements will be operated on the strategy and the second draft will be elaborated. The last two steps of the process are the Consensus Building and the Launching of the strategy.[6]

[6] The elaboration of the second draft as well as the last two steps will take place after the date of the submission of the dissertation.

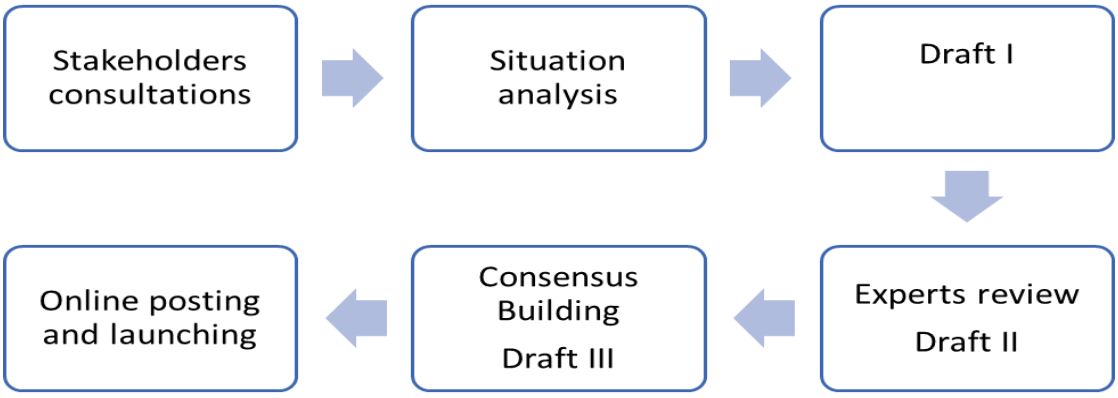

Figure 6: The development process of NISCVT's mental health strategy.

3.2.1 Stakeholders consultations

Due to the growing size of NISCVT's mental health programme, a steering committee was formed in December of 2016, regrouping specialists, community workers, centers' directors, board members and a consultant from the Ministry of Health. The committee's role is to follow-up on the development of the mental health strategy. The author of the present dissertation, who has a long experience of working in the programme, was assigned by the steering committee to facilitate the strategy development. Thus, this dissertation will serve as NISCVT's mental health strategy. It is noteworthy to mention that this project is perceived as a crucial need for the programme by all the stakeholders (as stated in interviews conducted by the author, see below). It also benefits from the technical support of the National Mental Health Programme (NMHP) which perceives the development of this strategy as part of its fifth domain of action targeting "Vulnerable Groups" (Ministry of Public Health 2015, p. 30). A first consultation meeting took place on December 1st of 2016, when Dr. Rabih El Chammay, Head of the National Mental Health Programme and psychiatrist within the NISCVT presented a brief on the national mental health programme and suggested a framework for the strategy's development process which is in line with the national strategy (see figure 7). Two following meeting took place on February 3rd and March 10th of 2017. Both meetings aimed at presenting the preliminary results of the strategy development process,

harmonizing all the different points of view and gaining the support of the major stakeholders (see Appendix 2 for meetings'minutes)[7].

Figure 7. Consultational meeting with the steering committee.

3.2.2 Situation Analysis:

The next step of the mental health strategy development process was to conduct a situation analysis which not only offers a better understanding of the programme's current situation but also is fundamental to design the programme's policy and plan, to identify critical issues and to set priorities. The situation analysis was conducted through a qualitative method comprising a desk and a literature review and in-depth interviews with key persons (psychiatrists, centers' managers, therapists, community workers, board members and the general director of the organization). This type of design provides an exploration of the stakeholders' perceptions being a key component of evaluating a programme. Therefore, it merits a qualitative approach. Besides, the qualitative design prevents a premature focus on a limited number of areas and provides more

[7] The author obtained the permission to use the meetings' minutes in this dissertation from the participants. For more details, contact the programme coordinator Ms Liliane Younes at: fgc.mental.health@gmail.com

flexibility in understanding the situation. This results in a comprehensive approach for detecting the areas and themes to be improved. In the section below, the literature review, the desk review and the in-depth interviews are explained in more details:

- The literature review comprised publications which are related to mental health and psychosocial support in emergencies, mental health epidemiological studies, social determinants of mental health, WHO's mental health policy packages as well as national studies on mental health in Lebanon, particularly in the Palestinian community.

- The desk review included the following documents: annual reports about the services, the filing system, previous evaluations of the quality of the mental health services, job descriptions, signed agreements with funding agencies, annual financial reports. It provided a detailed view on the different activities and interventions across the centers, the evolution of the services over the years, the most frequent treated disorders, the staff's working hours, the differences in services between the centers, the roles and responsibilities, the articulation between the staff within one center and between the centers and the financing of the programme.

- The in-depth interviews are an essential element of this study, as it reveals the stakeholders' own assessment of the current situation. As such, to 17 key persons semi-structured interviews were applied. The open-ended questions of the semi-structured interviews were intended to obtain elaborate answers on specific themes and issues considered critical. Sub-questions were also prepared to help the respondents elaborate more their ideas when needed. The closing of the interviews contains a part for suggestions for improvement. All of the interviews were audio recorded, so that no information is missed out. Consent forms were signed by the respondents (see Appendix 1). The answers were transcribed. The setting of the interviews was considerately chosen, avoiding interference as much as possible. The duration of the interviews did not exceed one hour.

The questions aimed at exploring the respondents' views on topics which cover WHO's principle areas of action in mental health policies (WHO 2005. p. 30) (see the topics below). The interviews start with a general question exploring their opinion about the need and the importance of developing a strategy for the programme and about its relevance. Under each topic, the respondents were asked to answer questions about how they perceive the current situation, the main successes and challenges, what is needed to make improvements, and other suggestions. The following is a list of the covered topics:

"1. Coordinating Unit
2. Financing
3. Legislation and human rights
4. Organization of services
5. Human resources and training
6. Promotion, prevention, treatment and rehabilitation
7. Essential drug procurement
8. Advocacy
9. Quality improvement
10. Information systems
11. Research and evaluation of policies and services
12. Intersectoral collaboration"

The respondents were selected on the criteria of their key positions and experience within the NISCVT. In total, seventeen respondents were interviewed but only twelve interviews were considered for the present analysis. The reason for this selection is due to the precise purpose of this strategy. The rest of the collected data does not contradict the present findings, which result from these twelve interviews, but the author and the steering committee consider that these twelve are sufficient and critical for the development and implementation of the strategy. In a further stage, the rest of the collected data can help to fine-tune services to more specialized services.

The major analysis of the data is thematic. The respondents' answers are coded into the topics described above which require improvement and then grouped into more encompassing areas:

(1) leadership and governance, (2) Re-orientation and scaling up of services, (3) prevention and promotion, (4) Information, evidence and research, and (5) Vulnerable groups. The choice of these specific domains is attuned to WHO's Mental Health Action Plan 2013-2020 (WHO 2013).
The findings of the situation analysis are organized in terms of strengths, weaknesses, opportunities and threats (SWOT analysis).

3.2.3 Drafting of the strategy

After the situation analysis, a meeting with the steering committee was held to share with them the findings and adjust any related critical issue. Also, an exercise was conducted by the author to formulate the policy's vision, mission, objectives, values and principles. Also, domains of action which require improvement were identified.
The following stage requires setting a goal for each domain of action to address the critical issues and to formulate strategic objectives to achieve the set of goals with targets of the successful achievement of these objectives.
Consequently, the first draft of the strategy was ready to be shared with the steering committee and with the ministry of health's consultant for an experts' review. This consultation and negotiation is still currently under process and it would result in the formulation of the second draft. Afterwards, it is very important to build a final consensus before producing the third and final draft. The last step consists in an online posting and a launching event of the strategy.
The development of the implementation plan which comprises the major activities, the actors, the resources and time, could not be developed in this dissertation because that requires more detailed internal planning for the NGO, which is highly dependent on external funding.

3.3 Limitations of study

The evaluator (the author of this dissertation) is part of the NISCVT staff. This, arguably, might lead to the suspicion of some bias in the conducted research. For instance, this might have influenced the respondents' answers. However, given the particular situation and expected outcomes, this study had to be conducted by a person with inside knowledge. An already experienced staff member of the FGC would be aware of the center's current situation, resources and needs. This strategy was developed to serve a heterogeneous population (different generations, ages, social situations), with complex socio-cultural dynamics, of Palestinian refugees in Lebanon. To begin with, the study needed to be conducted by a person who knows how to relate and understand the difficulties that people working with refugees might face. Also, this led to the grounding of the theory and of the strategy in the social reality of the refugee camps. Besides, the decision of having an existing member of staff develop the strategy was financially helpful, given the limited resources of the NGO.

Another limitation stands in the time that the development process of the strategy requires in order to be completed. The experts and stakeholders' reviewing and editing requires significant amounts of time. Such feedback cannot be provided and implemented during the first phase of the strategy's development, which largely coincides with the present dissertation. Nevertheless, the present document is considerate of internal, on the field feedback, as it is comprehensive of a second draft of the strategy after the experts' review. The author will be collaborating with the NGO on the topic of the strategy at least until the launching of the strategy and the implementation of the plan.

Another barrier consists in the scarce scientific publications related to the mental health of the Palestinian community, especially the young, in Lebanon. Most of the available information is in the form of anecdotal evidence: lessons learned, experience-based guidelines and unpublished external programme evaluations. Scientific knowledge about mental health prevalence, incidence, determinants, availability and effectiveness of the services would have been very valuable in tailoring better the mental health strategic objectives to this community's specific needs. The present dissertation is, in its own right, thought limited, a contribution to the scientific literature on this community's mental health situation.

A last limitation to be noted resides in the difficulty of including the users group in the interviews during the stakeholders' consultations. Focusing on only one group of participants, namely the staff, was necessary to avoid mixing variables and to enable data analysis. Also, the time limitations and the need for a swift implementation of a first plan served as arguments for interviewing of one group only, to begin with. The users' views and satisfaction of the services were collected through the anecdotal records. However, the participation and the involvement of the users in the planning of the services will be integrated in the subsequent stages of the implementation of the strategic objectives related mental health advocacy, human rights, organization of the services and quality improvement.

3.4 Ethical considerations

There is no risk associated with this research. The NISCVT and all the stakeholders involved also consider so. The respondents' participation was voluntary. Consent forms containing all information related to the study are signed prior to the interview. Confidentiality is preserved through anonymization of the data. Notes and transcripts from the interviews were accessible only to the author of this study. Also, the analysis and the summary of the data in this report is written in a way that does not allow the attribution of any response to an identifiable respondent.

3.5 Results: Summary of the SWOT analysis.

A SWOT analysis of the current mental health programme of the NISCVT is insightful for formulating a strategy because a strategy must include specific proposals to address challenges, avoid threats, build on the existing strengths and seize the opportunities. The data for the SWOT analysis was collected from the interviews, the desk and the literature reviews.

3.5.1 Strengths

The mental health programme of the NISCVT presents five main strengths: (1) its leadership's commitment to support and improve the mental health programme, (2) its human resources, (3) its

established collaborations, (4) its orientation towards a community-based model and (5) its reputation. The first strength refers to the support that the board of directors show to the mental health programme through their commitment and their engagement to advance the mental health services. The human resources constitute one of the programme's strengths because the existing staff acts upon ethical values and organizational standards and are self-motivated. As most of the human resources are involved stakeholders, they have the motivation to strive for continuous improvement and for delivering services as good as possible to their own community. Also, the multidisciplinary team approach adopted by the organization contributes to a holistic care and a diversity in the services provided. These allow for a wide variety of services offered. The programme's third strong point entails in its well-established network of partners on various levels, such as other programmes within the organization, service providers in the community, national organizations and some long-term international supporters. The mental health programme of the NISCVT has a close collaboration with these partners on the levels of funding and technical support for its programmes which allowed it to expand and grow. The fourth strength of the programme consists in that, by already observing the need for a community-based model, the team in El-Buss started to develop such a model through the integration of task-shifting in its services under specialists' supervision, the running of parental support groups, the creation of a parents' committee and home awareness stations. Developing a community-based strategy is needed to render the programme more effective, therefore the experience of the El-Buss team can support the other teams' orientation towards a community based programme especially after having these experiences documented, published and shared. These documents represent important resources for other teams, detailing elements of good practices. The programme's fifth strength stands in its acquired reputation and wide exposure among donors, stakeholders and the community in general during 20 years of serving the Palestinian refugee community. A recent evaluation of the orientation of the programme[8] (done in four centers except the one in Beirut[9]) towards a

[8] Khalidi A., 2016. *Towards implementing Community Based Mental Health Framework at NISCVT/BAS FGCs in North and South Lebanon*. Ministry for foreign affairs of Finland. It is an unpublished report. For more information, please contact sirkku.kivisto@gmail.com.

[9] The mental health programme in Beirut's center has some specificities: (1) being geographically situated far away from the camps and (2) employs few social workers. These specificities define the way the services are organized. It therefore functions differently than the other four centers whose services are more community oriented and accessible. The Beirut center therefore functions as an outpatient clinic where most of the rehabilitation services

community based programme found that services enjoy a high level of acceptability. This was shown by the high satisfaction of the users, staff and main stakeholders.

3.5.2 Weaknesses

Despite the commendable efforts and work done by the organization, multiple weaknesses characterize the mental health programme of the NISCVT, hindering its progress. These weaknesses are considered areas of improvement and shall be addressed to build a solid foundation for a sustainable programme. These areas of improvement are found on the following levels: leadership and management, the organization of services, the research and health information system, the awareness and prevention.

On the leadership and governance level, the programme has been operating without the support of a (1) clear policy. Therefore, there are no common vision, mission, values, goals and priorities across all the teams and centers. Without some shared ideas about the governance of the programme the work risks to be fragmented and inefficient at times and the services would lack focus on specific targets and goals. (2) Moreover, as the centers become more active and as the work is expanding into other non-clinical community mental health activities, monitoring both the technical and managerial levels, becomes increasingly important. At the present time, the absence of a full-time programme coordinator makes it difficult to harmonize, unify, strategize and organize the work across all the centers. This leads to another challenge related to (3) the internal communication between the staff across all the centers. Many of the staff, especially the part-timers are not informed enough regarding required technical and managerial issues. The sharing of experiences and skills between the different mental health teams is poor. The meetings agendas are not always circulated in advance which affects the preparation and the quality of the inputs. The staff sometimes misses important meetings because of other work commitments, of the absence of regulations in what concerns attending meetings, as well as of the need to commute from far away. These issues result in an inconsistency in care delivery and a disparity in management and quality across centers. Also, there are no written (4) work regulations and the

following the clinical one on one model. However, the center puts large efforts into networking and linking with other programmes within and outside the organization.

reporting structure in place is not formal. When it comes to (5) the human resources, the lack of qualified Palestinian professionals represents an important challenge. Having qualified Palestinian mental health professionals in the programme will allow the local community to become more socially and professionally empowered and to take its development in its own hand. The existing staff are facing many issues among which: unclear and overwhelming tasks especially for the community workers, understaffing in some centers, risk of burnout, lack of psychological support for the staff, low wages and absence of work incentives for the community workers which affects their job satisfaction and decreases the staff retention, the absence of an objective and anonymous reporting system for the staff's demands and complaints, poor physical environment (e.g.: lack of space, poor thermal and sound isolation…). One weakness that some centers present stands in not having an appropriate manager for their mental health services. This human resource problem is due to an organizational situation. Mental health services should be managed by professionals experienced in mental health and social work. While this is the case in some areas for some teams, some do not have a manager with the appropriate expertise in this area. The latter situation is due to specific centers being organized as part of wider structures encompassing all the range of services (kindergartens, reproductive health programme, dental clinic, peer education programme…). The managers of these all-encompassing centers thus appoint social workers to be in charge of the mental health services. However, the appointed specialists in charge do not have the managerial authority needed to implement policies and take actions efficiently. Finally, the (6) financial infrastructure shows many gaps such as: The absence of a fundraising unit specialized in writing proposals and fundraising, the lack of standardized financial policies and procedures, an understaffed financial department, the absence of a yearly financial planning, the funders' preference for short-term funds. The financial uncertainties faced by the programme have led to submitting funding proposals targeting areas and activities that are of interest to the donors but not necessarily to the organization. Another effect of the short-term outlook is the dissatisfaction of the staff (especially the specialists) and their fear to commit more time to the programme due to the unsustainable resources.

The organization of services is a major area of improvement where a whole set of challenges is faced. Until now the Community Based Model has been carried out by means of trials and errors.

Due to various funding circumstances, the centers function independently with different models of organization of services. Thus, among the staff there lacks an awareness of belonging to the same organization. This is observable at both an informal level and at the level of formal procedures. In many ways, the model still functions in a clinical way: in many centers, the user is received once a week or biweekly and is offered individual treatment sessions for a long time and with low participation from parents. This model has remained unchanged in most of the centers despite the increase in the demand on the services that is coupled with the increase in the waiting lists. The difficulty of some teams in scaling up their services is mostly due to the shortage of community mental health workers to conduct outreach activities such as awareness sessions, home visits, school visits. There is a reluctance among some staff members to change the model of care. The lack of agreement and of procedures around the target population, the interventions, the pathways of care, the channels and the time and resources created confusion among the staff and increased the workload.

Mental health awareness and promotion is not perceived as a priority at the same level in all the centers. It is happening on a small scale at the center, mainly after the treatment sessions while debriefing with the family members, or on occasional seminars on mental health topics. There is a poor or lacking collaboration between the different existing programmes (the kindergartens, the family happiness and the peer education programmes, etc.). A better collaboration can result in a more efficient focusing of resources and promotion of mental health topics. The groups that need to be targeted are: new parents, women of bearing age, primary care doctors, teachers, nurses and religious figures.

The health and information system also presents a major gap, there is no unified electronic system to collect/generate data to inform decision makers on the prioritization and development of the services. Forms for medical records, for communication, and for administrative procedures differ from one center to the other. This creates inefficiency and hinders the smooth flow of information within and between centers. Research is a weak area due to a lack in human and financial resources. Limited research implies a low ability of the programme to generate and publish evidence for locally adapted interventions.

3.5.3 Opportunities

The international, national and local environments offer many opportunities which are important to capitalize on to develop and implement the strategic plan of the mental health programme effectively. Firstly, there are advances in the publication of international guidelines and evidence based practices in mental health which can serve as a framework to the organization of the services. Secondly, the mental health reform is underway on a national level. The national mental health strategy for Lebanon 2015-2020 includes a domain of action related to "Vulnerable Groups", among whom the Palestinian refugees. This offers a window of opportunity to advocate for the mental health of Palestinian refugees on a national level and to benefit from the support of the Ministry of Health. Thirdly, on the same level the American University of Beirut offered to sign an agreement of understanding with the mental health programme. This agreement involves having interns from the AUB, more specifically from its psychiatry programme doing an internship in the mental health services of the NISCVT. This intended collaboration with such a high- profile university will add more visibility and credibility to the programme. Fourthly, on a local level the existing literature on the mental health of the Palestinian refugees in Lebanon represents a good base to understand this population's needs and the social determinants affecting their mental health. Additionally, there are many other NGOs locally who offer parallel or complementary services with whom the mental health programmes can create new agreements and referral procedures. The organization has complementary programmes where mental health services such as promotion, prevention and detection, can be integrated when more effective referral procedures and staff training will take place. There are plans to develop a fundraising infrastructure which will increase the sustainability of the programme.

3.5.4 Threats

The threats on the mental health programme are very important to consider in order to reduce their impact or to avoid them.

The first threat is the precarious socio-economic situation in which most of the Palestinian refugees live in, which makes them more vulnerable to developing mental health disorders or it could

worsen already existing ones. High rates of poverty, low educational attainment, overcrowded home environment and high unemployment rates are widespread social determinants in the Palestinians camps and gatherings. They stem from the lack of civil, social, economic and political rights of Palestinian refugees in Lebanon. The second threat is related to the strain and the budgetary cuts on the educational and health system in UNRWA services. The health and educational services being affected, this will impact the overall health level and educational prospects of the population and therefore increasing the risk of mental health issues. On this level, another issue occurs in the lack of the integration of mental health services in UNRWA's primary health care services. This problem created an increased demand for mental health services on the secondary care level such as the mental health programme of the NISCVT which has long waiting lists in all its centers. Thirdly, there are widespread cultural believes and behaviors in this particular community which predispose individuals to high risks of developing mental disorders such as: marriage amongst relatives, physical punishment, early marriage, family interference. Security problems in the camps (for example, the armed conflicts which took place in Ain El Helwe or previously in Nahr El Bared) constitute the fourth threat facing the mental health programme. The fifth threat to be added is the elevated level of stigma surrounding mental health and neurodevelopmental disorders in the Palestinian refugee community. Additionally, since the start of the Syrian crisis, the number of refugees in Lebanon increased dramatically which created strains on many services in the country including the mental health programme of the NISCVT. Finally, some countries' austerity measures affected the funding of projects within the programme.

The strategy is elaborated in light of this analysis. In the next chapter, the policy elements will be explained (the vision, the mission, the objectives, the guiding principles and the values). After the policies are explained, the areas of action will be defined. Each area has a main proposal or goal. Also, major strategies for the implementation of the proposals are identified. Finally, targets for the successful achievement of the strategic objectives are developed.

4. The Mental Health Strategy for the National Institute for Social Care and Vocational Training for 2018-2021.

This current chapter describes the first draft of the mental health strategy. It entails the major elements of a mental health strategy, which were formulated through a collaborative and a consultational approach.

4.1 Vision

The following statement represents the vision of the mental health programme of the NISCVT:
The Mental Health of children and adolescents and their families within the Palestinian refugee population and among the most deprived categories from other nationalities living in Lebanon is protected and promoted as a fundamental and basic human right.

4.2 Mission

The mission of the mental health programme of the NISCVT is represented in the following points:

- A Sustainable mental health programme that provides a good accessibility of high quality mental health services.
- Prevention, Treatment and rehabilitation of mental health disorders.
- Promotion of mental health wellbeing.
- The target population is: children and adolescents and their families within the Palestinian refugee population and among the most deprived categories from other nationalities living in Lebanon.
- This development will happen through an orientation towards a community based, an evidence based and a cost-effective model.
- The services will follow a recovery approach[10] where the emphasis will be on human rights, cultural relevance and community participation.

[10] "For many people with mental illness, the concept of recovery is about staying in control of their life rather than the elusive state of return to premorbid level of functioning. Such an approach, which does not focus on full

4.3 Values and guiding principles

In addition to the concept of "evidence", policy makers also use that of "value" in the framework for developing mental health policies. According to Shams et al. (2016, p. 623), values play a significant role in a decision-making process:

"Values are considered [an] important component of policy-making and health system reforms […] they are recognized as deep-rooted beliefs that affect objectives, decisions, behaviors, and policy implementation" (Shams et al., 2016, p. 623).

During the stakeholders' consultation meetings (section 3.2.1 p. 30), the steering committee which is participating and overseeing the development process of this strategy advanced a set of values and guiding principles that the mental health programme needs to hold in order to guide the provision of mental health services. These values and principles are inspired from the recovery approach which is to be adopted by the programme and they are detailed in the section below:

Professionalism

The mental health service providers will improve professionally by following personal and professional standards which are defined by a regulatory framework, by adhering to an ethical and professional code of practice, by developing their professional expertise and by delivering a safe and effective service.

Teamwork

The mental health teams of the NISCVT will work closely, forming an interdisciplinary team. Mental health professionals and community health workers within the same center and across all centers will collaborate closely and communicate regularly by sharing discussions, practices and experiences. Teamwork and collaboration are core practices of the mental health programme of the NISCVT. Team cohesion implies a good understanding of the needs of the population which in turn helps the providing of adequate care.

symptom resolution but emphasizes resilience and control over problems and life, has been called the recovery model. The approach argues against just treating or managing symptoms but focusing on building resilience of people with mental illness and supporting those in emotional distress" (Jakob 2015, p.117)

Quality of services

The mental health programme of the NISCVT will strive to deliver services that meet quality criteria. Services will be based on scientific research and evidence-based guidelines. They will also be safe, timely, equitable and efficient.

Trust and Respect

Relationships which are based on trust and respect between the different disciplinary groups and with the users, will be developed in order to establish effective inter-professional relationships. This can happen through a clear identification of roles and through the development of professional identities.

Comprehensiveness

The services will focus on comprehensiveness and continuity of care for Palestinian youths and their caregivers. The programme will strive to provide a wide range of mental health services following a biopsychosocial model[11] which considers the person as a whole.

Social inclusion

The strategy will promote social inclusion of children and adolescents with mental disorders by supporting their rightful access to mainstream services such as schools, community life and activities. The youths and their caregivers will be encouraged to participate actively and fully in the care process and to advance contributions to the programme and to the community.

Dignity, privacy and Autonomy

By grounding the programme in respect and promotion of human, especially children's rights, the preservation of the dignity of the users must be ensured. The users' privacy and information confidentiality will be preserved. The families and users' autonomy will be respected and their

[11] The biopsychosocial model was introduced by the late George Engel in 1977. In his paper *The need for a new medical model: a challenge for biomedicine* (Engel 1977). Engel believed that clinicians should address the biological, psychological and social factors of illness, in contrast to the prevailing biomedical model at the time (Borrel-Carrió 2004, p. 576).

agency will be encouraged and protected. They will be free from any constraints that might affect their freedom and their decision-making.

Partnership with the caregivers and users

The programme will train the mental health providers to empower families with the skills needed to be active partners. Families will be included in the treatment process, as they play a major role in facilitating the recovery of their children. To achieve this purpose, caregivers will receive the information, education, training and emotional support that they need.

Preservation of cultural identity

The present study argues for the need of a further investigation on the interrelations between mental health and the cultural identity of the community of Palestinian refugees in Lebanon. The theme of identity repeated plentifully in the interviews, but without an in-depth anthropological study on the topic, the concept is largely vague. Besides, it is not clear whether "Palestinian identity" means similar things for most Palestinian refugees, as individuals' discourses on "identity" widely differ. For instance, while many respondents emphasize on the need of identity, some discuss cultural identity, others discuss social identity and others focus on personal identity. This should therefore be further explored in the scope of the implementation of this strategy. The use of culturally appropriate mental health services for minorities has been acknowledged by research in mental health (Wallen 1992, p. 288). Wallen (1992) claims that cultural factors represent one barrier among others (economic, access issues) to the use of out-patient mental health services by minorities. To address these barriers which can hinder the use of services by the Palestinian community, the next step for meliorating Palestinian refugees' access to mental health services, after the implementation of this strategy, should consist in an investigation on Palestinian identity.

Empowerment and Participation

Families will be at all times involved in decision-making on mental health services. Being involved in decision-making empowers this community and contributes to its autonomy, being a practice of taking responsibility. The programme will encourage users and carers to increase their level of choice, influence and control over the events of their own lives. This can be achieved by including the users and families in the planning, provision and evaluation process from the early stages.

Accountability

A high level of accountability will be maintained at all levels to ensure that funds are used towards achieving efficient and effective outcomes. Appropriate mechanisms will be put in place to continuously set expectations, monitor performance, report outcomes and make suggested improvements.

4.4 Objectives

The objectives are developed in accordance with the WHO's overall strategic objectives for developing mental health policies: improving the health of the population, responding to people's expectations and providing financial protection against the cost ill of health (WHO 2005, p. 4)[12]. As such, the objectives of the present strategy are the following:

- Providing evidence based and cost-effective treatment tailored to the needs of a larger number of Palestinian children, adolescents and their caregivers who present mental and neuro-developmental disorders;
- Increasing the accessibility of mental health services to the local community.
- Providing comprehensive and high-quality services.
- Developing care pathways at the center and at the community level for the different users and their families.

[12] Mental health policy, plans and programmes (updated version 2). Geneva, World Health Organization, 2005 (Mental Health Policy and Service Guidance Package), p.4.

- Preventing mental and neuro-developmental disorders and promoting mental health of the Palestinian refugees' population.
- Promoting the human rights of Palestinian children, adolescents and their caregivers;
- Contributing to the development of informal community health services in the Palestinian community by collaborating with schools, other NGOs and supporting family associations.

4.5 Goals and Domains of Action

The goals and domains of action of the Mental Health Strategy for the NISCVT 2018-2021 are in line with the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon 2015-2020 and the WHO Global Action Plan for Mental Health (2013-2020).

The domains of action represent the main areas or themes of improvement in the strategy. For each area, a goal is developed in order to address critical issues (see table below). Taking into account these challenges for the coming three years, core strategic objectives are identified, formulated and grouped under each domain of action. In conclusion, targets for the successful achievement of these core objectives are developed.

Domains	Goals
Leadership and Governance	To strengthen effective leadership and governance for mental health
Reorientation and Scaling-up of mental health services	To provide comprehensive, high quality and evidence-based community mental health services following a needs-led model. The services are grounded in the principles of accessibility, effectiveness, coordinated care and respect for human rights

Prevention and Promotion	To Build systematic approaches to the protection and promotion of youth mental health
Mental Health Information, Evidence and Research	To increase the information and evidence-base on mental health of Palestinian youths and their caregivers. This information, obtained through an effective health information system and regular research, will be used to inform the planning of the mental health programme and to develop the services.
Vulnerable groups	To increase the accessibility of mental health care for children, teenagers and their caregivers in the most vulnerable categories

Table 2. Areas of action and goals of the mental health strategy for NISCVT

4.5.1 Domain 1: Leadership and governance

Goal: To strengthen effective leadership and governance for mental health.

4.5.1.1 Governance of mental health

Interventions will focus on expanding and regulating the role of the current strategic committee which oversees the development of the strategic policy. The committee will continue to provide monitoring and support for the mental health strategy development, planning and implementation process.

This requires the establishment of a common governance structure. The Steering committee will work to unite the programme among the 5 teams. Also, it will collaborate with sister programmes within the NISCVT, other NGOs and entities on the local and national level to ensure the implementation of the strategy. The committee will engage a programme coordinator who will be in charge of liaising with the mental health teams and with the steering committee on an internal level and of overseeing daily activities.

Strategic objective 1:

Establish a sustainable official steering committee that oversees the implementation of the strategy and leads on strategic decisions related to the mental health programme.

Targets:

-The identification of the members of the steering committee is finalized within the first three months of 2018.

-Have a first introduction meeting for the members of the steering committee within the first three months of 2018.

-TOR of the steering committee are set in a clear document and approved by the higher management within the first quarter of 2018.

-Leadership and governance training workshop is done by the end of the first quarter of 2018.

-Biweekly or monthly regular meetings, meeting minutes to be shared with the team members.

Strategic objective 2:

Appoint a full time programme coordinator.

Targets:

-One full time coordinator or 2 part-timers is/are recruited externally or assigned internally and his/their TOR are set in a clear document and approved by the higher management and the steering committee by the first quarter of 2018.

-10% of the SOP (Standard Operating Procedures) to be set April 2018.

Strategic objective 3:

Standardize and disseminate the mental health policy's main elements among all employees: vision, mission, values and principles as well as the domains of action.

Targets:

-Meetings and emails are exchanged regularly between the steering committee and the strategy development facilitators.
-Design and print the vision, mission and values in Arabic and English on the website and the premises of the centers during the first 3 months of 2018.
-Strategy printed by the first quarter of 2018.
-Strategy posted on the website of the NISCVT by the second quarter of 2018.

Strategic objective 4:

Develop customized strategic plans per area/team. The strategic plan will take into consideration the areas of highest priorities of the communities in which they work.

Targets:

-A focal person from each team is identified by the end of the first quarter of 2018.
-Meetings are conducted regularly among the focal persons and the coordinator.
-A customized strategic plan per team is finalized by the third quarter of 2018.

4.5.1.2 Management

Interventions will focus on the implementation of managerial interventions at the communication and regulations levels. The purpose is to arrive at a more coherent and sustainable working environment.

By creating a robust managerial system, the programme has more chances in achieving its objectives. The development of in-depth processes related to the internal communication allows the staff to have better access to required information, thus resulting in improving the

cohesiveness, efficiency and effectiveness of the programme. The strategy would include means of communication between members of each team at the horizontal and vertical levels (with the management). The strategy will also revise work regulations related to the mental health programme, review the background and the requirements for the leaders and managers of the centers and set a systematic reporting system.

Strategic objective 1:

Develop a communication plan including processes which regulate the communication between the members of each team across the 5 different centers.

Targets:

- A task force is identified and established to lead on the communication strategy by the second quarter of 2018.
- Focus groups with the teams will be done by the end of the second quarter of 2018.
- A situational assessment of the internal communication of each team followed by an implementation plan, per team, will be ready by the end of 2018 (last quarter).
- The communication plan will be disseminated and adopted by the teams by the beginning of 2019.
- Monthly follow ups of the implementation of the plan will take place.

Strategic objective 2:

Develop a communication plan including processes which regulate the communication between the mental health teams in all areas/centers providing mental health services of the NISCVT.

Targets:

- An internal communication assessment (consultation with stakeholders is necessary) is done by the third quarter of 2018
- The communication plan will be finalized and disseminated to all the staff by the second quarter of 2019.

-Monthly follow ups of the implementation of the plan will take place.

Strategic objective 3:

Develop a communication plan including processes which regulate the communication between the mental teams and the higher management.

Targets:

-The communication assessment (consultation with stakeholders is necessary) is done by the second quarter of 2018.
-The communication plan will be ready and disseminated to all the staff by the last quarter of 2018.

Target for all 3 activities: A quarterly newsletter (paper or electronic version) or monthly brief letters will be produced and mailed to all the staff and to the board of directors including details on the programme's policy, strategic direction, staff movement, events, managerial decisions and other useful information…the newsletter encourages interaction through calls to action (CTA): "tell us what you think, register for an event, download an article…"

Strategic objective 4:

Develop an inter-cultural communication plan which aims at increasing the interaction between Lebanese and Palestinians.

Targets:

-The quota on Lebanese users is set and disseminated among all the teams by the first quarter of 2018.
-Internship vacancies will be advertised in mental health related academic departments (psychology, social work, speech therapy, psychiatry, public health, psychiatric nursing, psychomotor therapy, occupational therapy), by the second quarter of 2018.

-Team building activities proposal will be written by the third quarter of 2018 with a clear agenda and the relevant budget will be calculated.

Strategic objective 5:

Set and disseminate fair and well communicated work regulations among all employees.

Targets:

-A work regulations manual will be finalized by the last quarter of 2018.
-Discussion of the work regulations per teams the end of 2018.

Strategic objective 6:

To update the organizational chart in a way to reflect a clear, structured and effective reporting mechanism among members across all levels.

Targets:

-The organizational chart will be updated by the first quarter of 2018.
-A systematic and anonymous reporting mechanism and pathways will be written and disseminated to everyone by mid-2018

4.5.1.3 Financing

Interventions will focus on ensuring sufficient funds in order to achieve and sustain the strategic goals of the mental health programme such as: the operations, the service delivery, the infrastructure, the technology and team capacity building.
This can be achieved by decentralizing the budget planning of the mental health programme from the rest of the programmes run by the organization, and by including the mental health teams in the budget discussions and preparations. The teams' participation will allow to project more precisely and to identify the programme's financial needs and priorities. Also, this leads to a better management in what regards setting limits to the expenditure by being aware of the available

budget. After revising the current budget, the NISCVT will develop a clear funding strategy in which resources will be reallocated and funds will be sought from international donors in order to ensure the necessary budget to implement the mental health activities listed in this strategy. The funding strategy can be multi-faceted which would ultimately encourage new donors to step forward. This will orient and support potential donors in their decision to finance specific sections that fall under their mandate.

Strategic Objective 1:

Implement a sustainable financial plan for the next 5 years.

Targets:

-A financial expert will be assigned or recruited by the first quarter of 2018.
-Financial mapping and budgeting will be finalized by the third quarter of 2018.
-Final budget will be approved by the end of the last quarter of 2018.
-Regular (monthly) budget management statements will be produced.
-Information system will be developed by the first quarter of 2019 to allow monitoring.
-Financial evaluations such as: cost-effectiveness analysis, cost-utility analysis or cost-benefit analysis, will be conducted by the end of 2019.
-The appointment of a grant officer to constantly search for existing funds by the second quarter of 2018.
-A list of new possible donors will be prepared by the second quarter of 2018.
-A fundraising proposal template will be drafted by the second quarter of 2018.
-Areas requiring long term funding will be mapped and prioritized by mid-2018.
-Long term funding proposals will be drafted by the mid- 2018.
-Separate modules or "stand-alone" sections of the strategic plan will be drafted by mid-2018, e.g: quality improvement, advocacy groups funding, policy development.
-Clear definitions of the partnerships with the funders (the existing and new ones) and their financial input will be set by February 2018.
-Mini-proposals will be drafted by mid-2018.

Strategic objective 2:

To streamline financial arrangements by making the procedures more standardized.

Target: Financial SOPs will be set by the third quarter of 2018.

4.5.1.4 Human rights

Interventions will focus on promoting and monitoring human rights, with a focus on children with disabilities and their caregivers. The interventions will emphasize on the users' autonomy, liberty, and access to health care.

It is crucial to ensure the protection of people especially children and adolescents with mental and psychosocial disabilities from violations of human rights. This can be achieved by developing an implementation plan of the current Child protection policy of the NISCVT[13]. This can be achieved through workshops dedicated to the staff, the users and the community and through the development of preventative and curative services which are in line with international conventions.

Strategic Objective 1:

Review and Implement the NISCVT's Child Protection Policy and Code of Conduct.

Target: The focal person is appointed by the steering committee by the second quarter of 2018.

[13] The child protection policy of NISCVT and the Code of Conduct provides standards to safeguard the health, safety and wellbeing of children, within its work across all areas of operations. The child protection policy and the code of conduct:

- "Define expectations in dealing with issues of child protection giving direction to all NISCVT staff, trustees, consultants, volunteers and visitors.
- Is based on the principles of the UN Convention on the Rights of the Child (1989): taking the best interest of the child as the basis for all behaviour, promoting development of the child and preventing harm;
- Is part of the contractual relation with NISCVT: not acting in accordance with may be reason for dismissal." (the NISCVT's Child protection policy document)

Strategic objective 2:

To assess the quality and the human rights standards

Targets:

-The implementation plan for the Child protection policy and Code of Conduct will be drafted and approved by the board of trustees by the last quarter of 2018.

-The WHO Quality Rights assessment on human right conditions will be conducted in the first quarter of 2019.

4.5.1.5 Media Communication and Advocacy

Interventions will focus on:

- Increasing awareness levels on mental health literacy and on the mental health programme of the NISCVT. This will result in a reduction of stigma and discrimination.
- Empowering all the mental health actors within the Palestinian refugees' community including the families using the mental health services, in order to advocate for improved mental health services.

The NISCVT's mental health steering committee will be in charge of developing a media and communication strategy. It will result in an increase of mental health literacy in the community by spreading knowledge about symptoms, causes, self-help and available services. Gains will also be made in the prevention, early intervention and community support. This will result in a larger coverage of mental health care through informal services. Also capitalizing on "marketing" strategies, increases the programme's visibility and the fundraising opportunities. This can be done at low cost by drawing on the organization's extensive network of friends, supporters and volunteers, universities and colleges. An advocacy strategy will also be developed with the main objectives to provide the support required for the consumers and the families empowerment and active participation, so that they can advocate for the needs of their children and for the community and to engage them in the planning and evaluation of mental health services.

Strategic objective 1:

To develop a media and communication strategy.

Target: A media and communication strategy document produced by the end of 2018. This strategy will be implemented during 2019 and evaluated by the beginning of 2020.

Strategic objective 2:

To develop an advocacy strategy for the beneficiaries and their families.

Target: An advocacy strategy is prepared commonly between the parents 'committees and the NISCVT by the end of 2019.

Sub-Objective 2.1:

To facilitate the creation of new parents' committees in areas where such committees do not exist.

Targets:

-A "parental committees" action plan is set up by the last quarter of 2018. The action plan is followed up and monitored yearly.
-Parents 'committees are created in all the areas with a yearly set agenda, and meet monthly starting the beginning of 2019.
-Parents with leadership skills are identified and trained on advocacy and community mobilization in mid-2019.

Sub-Objective 2.2 : To Develop a parents' support programme which will address the parents or caregivers' needs and concerns and will provide them with the necessary support in dealing with the stressful situations related to having children with special needs.

Targets:

-Facilitators of parents support groups are assigned and trained by the end of 2018. They must have a background in counseling, social work or group facilitation. They should also have skills in understanding group dynamics and interpersonal communication.
-A survey, listing possible topics for training, discussions and best day and time, is prepared then filled by parents by the end of 2018. Survey data is then analyzed and a programme is consequently prepared.
-Parents support groups are created and started by the first quarter of 2019 on a monthly or biweekly schedule.

Sub-Objective 2.3 :

To develop a Parental skills training programme.

Targets:

-Committees are formed per specialty across all the teams (e.g: psychologists, speech therapists…) by the last quarter of 2018. The coordinator does the follow up of the committees.
-Parental skills training programme packages are designed by these committees by the first quarter of 2019.
-The Parental skills training programme is piloted for a year starting the second quarter of 2019.
-The programme is evaluated after one year of its implementation.

4.5.2 Domain 2: Reorientation and Scaling-up of Mental Health services

Goal: To provide comprehensive, high quality and evidence-based community mental health services following a needs-led model. The services are grounded in the principles of accessibility, effectiveness, coordinated care and respect for human rights.

4.5.2.1 Organization **of services**

Interventions will focus on:

- Improving care provision by designing a mix of mental health services for the Palestinian children and youths and their caregivers with various levels in order to meet their needs, through a recovery oriented approach.
- The mental health services will be re-organized on the principles of the balanced model of care (Thornicoft and Tansella 2013). On an organizational and preparatory levels, packages will be developed to strengthen the human resources and capacity building in the form of training modules. On the service delivery level, a mix of services will vary between home based rehabilitation services and center-based therapeutic services where a two-way referral system will be developed. Packages will focus on standardizing tools for the detection and treatment of mental health disorders for children, youths and their caregivers using evidence based guidelines. The most complex or severe cases will be referred to the mental health clinicians at the center. Whereas, simple packages of care will be delivered through community health workers under specialists' supervision. This approach of care can be achieved through the task shifting and the Community-Based-Rehabilitation models CBR which were applied previously by the mental health teams and which have shown an elevated level of acceptability and effectiveness. These approaches will be standardized and disseminated. This articulation between specialists and non-specialists is expected to result in a better management of the limited human resources and a larger coverage of the needs of the community. This way, the services will be of high quality and evidence based.

Linkage and referral systems with other formal and informal service providers within the mother organization and in the community, will be established. Collaboration mechanisms will be signed with the official health and education service provider for the Palestinian refugees: the UNRWA (schools and primary care clinics). On this level, procedures regarding detection and cross-referrals will be set with UNRWA services, NISCVT programmes and other NGOs.

Services will be provided by the following range of personnel: medical professionals (psychiatrists), therapy professionals (occupational therapists, psychologists, speech therapists,

psychomotor therapists, physiotherapists, special educators) and community rehabilitation workers. Rehabilitation services will be offered in two settings: the clinics (the Family Guidance Centers), or the families' homes.

Strategic objective 1:

To design a balanced model of care based on the principles of the community based rehabilitation model, with various levels of intervention.

Targets:

-A baseline assessment of the existing services is conducted by the second quarter of 2018.
-The following indicators of the projected model of care, are determined through a consultation process with stakeholders by the last quarter of 2018.

a. The target population
b. The outcomes of the services
c. The pathways of care
d. The interventions: early detection procedures and evidence-based treatment protocols, development of eligibility criteria for each level of care with clear referral procedures.
e. The channels.
f. The time and the resources (Human resources, medication and equipment requirements and an estimation of the cost of implementation of the mental health plan).

-A design of the new model of care is drafted by the second quarter of 2019 and implemented as a pilot project for a year.
-The model of care is evaluated during the last quarter of 2020.
-The model of care is revised and scaled up by the end of 2020.

Strategic objective 2:

To establish a clear referral and linkage system between the NISCVT's specialized mental health services and the mental health service providers in the community on the local, regional and national levels.

Targets:

-Linkage procedures with UNRWA's[14] educational and welfare services are standardized with specific referral criteria by the last quarter of 2018.

-Criteria for referral to and from UNRWA's mental health services are developed in collaboration with UNRWA service providers during the first quarter of 2019.

-A summary of the mental health services of UNRWA is prepared by, for instance: staff, medications, equipment by the first quarter of 2019.

-Regular meetings are conducted (monthly) between technical coordinators/ mental health managers or an appointed service provider.

-MHPSS task force meetings are attended monthly by the mental health programme's representative (technical coordinator).

-A referral and linkage system is established with mental health service providers on the secondary level of care by the first quarter of 2019. Referral criteria are set in order to refer users who don't fulfill the eligibility criteria of the NISCVT's targeted population, such as the adults, the elderly, users with drug and alcohol addiction.

-Mapping of providers of informal community mental health services by the second quarter of 2018.

-Referral criteria to informal services are developed by the last quarter of 2018.

-Mapping of different services in the different health, legal, educational and social sectors mentioned above by the last quarter of 2018.

-Intersectoral linkage procedures with: child protective services, vocational rehabilitation programmes, educational systems, legal services, criminal justice system, drug and alcohol prevention and treatment programmes will be developed by the first quarter of 2019.

[14] UNRWA is currently working on integrating mental health services in primary care. Also, an MHPSS (mental health psycho-social support) coordinator was appointed to increase the interventions.

4.5.2.2 Human resources:

Interventions will focus on:

-Creating a Human resources plan which will cover the recruitment procedures, the capacity building and the personnel policies.

Human resources represent an essential component in the development and success of any mental health strategy. It is more likely for the mental health programme to meet the existing need if recruitment and retention strategies are well designed and implemented:

- The programme will therefore seek to implement new recruitment strategies that aim at ensuring the sufficient number of highly skilled staff to perform the services. This would be done through recruitment of new employees and reallocation of existing staff to fulfill the needed positions.

- Retention of highly motivated and equipped employees will take place through capacity building plans and incentive schemes:

1) Training plans will target the needs of the mental health specialists as well as non-specialists. Also, inter-teams trainings will ensure continuous sharing of experience and knowledge. The trainings will be aligned with the broad goals and objectives of the programme and will touch upon awareness raising, prevention and curative care and follow up with the community. A training plan for the staff of the other programmes (informal services) of the NISCVT will be designed, on detection and referral of childhood and youth mental health disorders. Such training will strengthen the network of social workers in the organization and the outreach in the community.

2) Motivation and incentives will be achieved through regular performance evaluation, monitoring of staff satisfaction, and improvement of the incentives and work environment.

Strategic objective 1:

Develop an effective recruitment policy.

Targets:

-A recruitment policy is produced in a clear document and approved by higher administration by the first quarter of 2018.

-A staffing needs assessment of clinical, non-clinical and administrative human resources, in line with the baseline assessment findings of the organization of services, by the second quarter of 2018.
-TORs of existing positions and projected ones are finalized by the last quarter of 2018.
-TORs of the coordinators need to be finalized by the first quarter of 2018[15].
-Job positions are advertised by the last quarter of 2018.
-Hiring is completed by the first quarter of 2019.

Strategic objective 2:

Develop capacity building proposals for clinicians, community mental health workers and other health and non-health workers from the community.

Targets:
-A capacity building plan for the community workers is developed by the last quarter of 2018
-A capacity building plan for the specialists is produced by the last quarter of 2018.
-Training packages for the staff: community workers, specialists and managers are developed by the first quarter of 2019.

Strategic objective 3:

Develop staff retention procedures.

Targets:
-The salary scale is adjusted as to reflect the workload by the last quarter of 2018. This will increase the staff retention and motivation which is lacking in most of the teams. It is important to take into account the community workers' years of experience in the salary scale which so far considers mainly their educational level.

[15] The TORs of the coordinators need to be finalized earlier for having these positions filled as early as possible is very crucial to the achievement of most of the strategic objectives.

- Financial incentives per salary scale are out in place, in order to maintain or increase the staff motivation especially with the community workers' high workload, by the first quarter of 2019. Non-financial incentives are also effective such as job security, praise of good work and accomplishments and the possibility of promotion.
- The system of payment for professional staff is amended in a way to consider other non-clinical duties as an integral part of their duties. These duties include: Professional regular meetings, administrative duties, outreach and education in the community as well as time needed for reflection and documentation of case progress and follow-up. This target will be achieved by the last quarter of 2018.
- A stress relief plan for the staff is developed, including low-cost leisure activities and team building activities as well counselling services for the staff when needed, by the first quarter of 2019.
- Mechanisms are put in place which will provide social workers with the necessary technical support and psychosocial care that they will need to ensure a high quality of the services and to avoid potential stress and burnout which might result from the dealing directly with persons suffering from disabilities and disorders. The target is achieved by the second quarter of 2019.
- Improve the physical conditions of the centers in terms of heating, aeration, humidity, sound isolation, sufficient space, by the last quarter of 2019.

4.5.2.3 Quality improvement

Interventions will focus on:

- Establishing and implementing quality assurance and improvement processes.

Improving the quality of care aims at ensuring and sustaining a solid foundation for the development of services by ensuring the optimal use of the resources and by applying the latest scientific knowledge in the use of treatments. Therefore, quality assurance and improvement mechanisms will be put in place such as the establishment of accreditation procedures, of a

monitoring and evaluation system and of the interventions which are in line with evidence-based and cost-effective services.

Strategic Objectives:

1. To develop standards and accreditation procedures.
2. To build a monitoring and evaluation system to ensure the quality of the mental health services
3. To ensure quality improvement in clinical practice through clinical practice guidelines, evidence-based interventions and teamwork.
4. To measure the performance of employees against such factors as: job knowledge, quality and quantity of output, initiative, leadership abilities, co-operation, and judgement. This target will be achieved starting the last quarter of 2019 and throughout 2020.

Targets:

- A monitoring and evaluation plan (goals, tools, responsibility and timeline) is prepared by the first quarter of 2019.
-A standards document is drafted by the second quarter of 2019
-Clinical guidelines are set by the second quarter of 2019.
-Monitoring and implementation plan is implemented during 2019 and corrective actions are taken by the first quarter of 2020.
-Assessments of employees' performance are done systematically

4.5.3 Domain 3: Promotion and prevention

Goal: Building systematic approaches to the protection and promotion of youth mental health.

Interventions will focus on:

- Developing and implementing secondary prevention interventions for children and adolescents with mental and neurodevelopmental disorders and for their families.

Through well implemented promotion and prevention interventions the burden of mental disorders in the society can be significantly reduced. Multiple meta-analysis reviews on secondary

prevention[16] programmes for youths have shown significant positive results, where the rates of future behavioral, emotional and learning problems were reduced (Weisz. et al. 2005. p. 629; Durlak. et al. 1998. p. 790). Thus, promotion and prevention constitute two core elements of any mental health strategy. Living in poor socio-economic circumstances, Palestinian youths and their families are at increased risk of developing mental disorders. Since the mental health programme of the NISCVT offers secondary mental health services, secondary prevention and promotion programmes will be developed by targeting evidence-based determinants of mental health in order to prevent the onset or the chronicity of cognitive, behavioral, affective, communication and learning disorders. The programme will therefore address risk and protective factors for youths and parents' mental disorders[17].The strategies will focus on early intervention of children at risk through community based interventions. Therefore, the interventions in this domain will seek to identify early signs of disorders and to offer interventions at an early stage of development of the problem. The prevention and promotion plan will be linked to treatment programmes through a unified framework. Such a framework will be developed in three stages: (1) the target population will be identified, (2) evidence based screening procedures will be used and (3) systematic evidence-based programmes will be implemented, tailored to the Palestinian context.

Also, selective prevention interventions will be developed and implemented through a collaborative approach between NISCVT's different educational, health, arts and cultural and recreational programmes and activities.

[16] "Secondary prevention involves intervention for individuals with subclinical-level problems" (durlak et al. 1998 p. 776)

[17]- Risk factors: "academic problems, attention deficits, low birth weight, child abuse and neglect, communication deviance, family conflict, reading disabilities, sensory disability, social incompetence and stressful life events."
- Protective factors: "Ability to cope with stress, Ability to face adversity, Adaptability, Autonomy, Early cognitive stimulation, Feelings of security, Good parenting, Literacy, Positive attachment and early bonding, Positive parent–child interaction, Problem-solving skills, Pro-social behavior, Self-esteem, Skills for life, Social and conflict management skills, Socioemotional growth, Stress management, Social support of family and friends ". (Retrieved from WHO's publication: *Prevention of Mental Disorders, effective interventions and policy options, p. 23)*

Strategic objectives:

1. Develop an evidence-based secondary prevention plan and link it to treatment programmes within an integrated model.
2. Establish a mechanism with NISCVT's other programmes and projects[18] in order to develop and implement an evidence-based selective prevention and promotion action plan.
3. Develop and Implement a selective prevention and promotion action plan.

Targets:

- A needs assessment report of mental health needs in the area of prevention and promotion is finalized by the last quarter of 2018.
- A prevention and promotion programme (policy and plan) is developed (target population, screening tools and procedures, training for the staff) by the first quarter of 2019.
- The implementation of the programme will take place through a pilot project starting the second quarter of 2019.
- The programme is evaluated on the basis of effectiveness and cost-effectiveness and revised one year after its implementation.
- The programme is disseminated and adopted among all the teams starting the third quarter of 2020.

4.5.4 Domain 4: Mental health Information, Evidence and Research.

Goal: To increase the information and evidence-base on mental health of Palestinian youths and their caregivers. This information, obtained through an effective health information system and regular research, will be used to inform the planning of the mental health programme and to develop the services.

[18] NISCVT'S projects include; kindergartens, pediatric clinics, family happiness/ psycho-social support/ reproductive health programmes and peer education, vocational training, remedial classes, drop-out classes. In addition to art and cultural projects, sports and scouts activities and women's project.

4.5.4.1 Health Information system (HIS).

Interventions will focus on:

-Developing a HIS to inform service planning and development by producing solid and reliable data.

An electronic HIS will be developed in the aim of enabling the development of evidence based programmes and of using the scarce resources in an optimal way (Health info system WHO p. 44). Data collection procedures will be standardized, users' mental health record forms will be designed and disseminated across all the centers. Also, mental health key indicators will be included in the HIS. After the data being collected, compiled, processed and analyzed, it will be communicated and used for many purposes among which the most important are: (1) monitoring and evaluation, (2) supporting the users' and the centers' management, (3) enabling planning, (4) stimulating research, and (5) conducting situation analyses.

Strategic objectives:

1. Design and establish a unified and user friendly electronic HIS.
2. Develop a set of mental health indicators and include them within the HIS.

Targets:

- An expert with a background in HIS is appointed by the second quarter of 2018.
- The current system of data collection is revised, the results are discussed with the steering committee and staff is consulted about what to include in the new system by the last quarter of 2018.
- Mental health indicators are set and included in the HIS by the second quarter of 2019.
- Data collection procedures are standardized the second quarter of 2019.
- Users record forms are designed and disseminated by the first quarter of 2019
- HIS is programmed and tested during 2020.

4.5.4.2 Research

Interventions will focus on:

- Developing a research agenda

By having a clear mental health research agenda, information and evidence on the mental health of the Palestinian youths and of their caregivers can be increased. This information constitutes an essential element to strengthen the NISCVT's mental health care programme and subsequently to improve the care and services to the Palestinian users and community. A clear research agenda will therefore be developed with appropriate human financial resources. It will inform developing and tailoring the mental health curative and preventive services in order to better meet the needs of this particular community.

Strategic objectives:

1. Create a research committee which would seek to create collaborations or apply for grants with national and international academic and research funding bodies.
2. Develop linkage with the national research agenda of the national mental health programme.
3. Conduct regular assessments using instruments such as WHO's "Assessing mental health and psychosocial needs and resources. Toolkit for humanitarian settings" (WHO & UNHCR 2012)

Targets:

- A research committee is created by the last quarter of 2018.
- A research agenda of the committee is set and disseminated by the first quarter of 2019.
- Links with the national research agenda are developed by the first quarter of 2019.
- An assessment of the services is conducted by the second quarter of 2020.
- Recommendations of the assessment are communicated and services are revised by the last quarter of 2020.

4.5.4.3 Evaluation of policies and Services

Interventions will focus on:

- Evaluating the progress of the current plan and informing future planning activities.

A Monitoring and Evaluation framework represents a key intervention in this strategy because it allows to understand whether the mental health policy and plan realized their intended goals, and to what extent (WHO., 2007, p. 2). A Monitoring and Evaluation framework will therefore be developed and implemented to keep track of progress and to direct service decisions and changes.

Strategic objective:

Implement a Monitoring and Evaluation framework for the strategy (see strategic objective 2.3.2).

Target: A monitoring and evaluation framework is developed by the first quarter of 2019.

4.5.5 Domain 5: Vulnerable Groups

Goal: To increase the accessibility of mental health care for children, teenagers and their caregivers in the most vulnerable categories among the Palestinian community.

Interventions will focus on:

-Designing and implementing a plan which targets vulnerable groups. The plan aims at providing comprehensive and evidence-based mental health curative and preventive mental health services.

It is very important that mental health psycho-social interventions are integrated in other programmes related to health, education, social development, and employment within the organization and other providers in the community. A coordination with the MOPH and UNRWA will be therefore be promoted.

The Palestinian refugees' community already meets major criteria of vulnerability, and more specifically the families who have children with mental and neurodevelopmental disorders, because of the high level of stigma and discrimination that they are subjected to, and the lack of accessible services. Not to mention that the whole Palestinian refugees' community faces stigma,

lives in poverty and encounters many restrictions in the exercise of their civil and political rights. Among the target population of the mental health programme of the NISCVT, some persons are at a higher risk of not accessing equitable mental health care. They represent the most vulnerable groups, and they are identified as:

- Children with intellectual and physical disabilities.
- Children victims of sexual and physical abuse.
- Children who dropped out of school.
- Children of parents with mental disorders.
- Palestinian displaced from Syria.
- Children in problematic families: children od deceased or separated parents.

Strategic objective 1:

Design and implement a plan targeting the vulnerable groups where evidence-based guidelines will be developed with a strong emphasis on family interventions and support.

Target: The mental health plan for vulnerable groups is developed by the first quarter of 2019 (in line with the development of the prevention and promotion plan, see strategic objective 3.3) and it would entail preventive and curative approaches. It would also encourage advocacy where children can participate in support groups and community activities.

Strategic objective 2:

Develop referral and linkage procedures with income-generating programmes, with educational and social programmes.

Targets:

- Referral and linkage procedures with development programmes are standardized by the second quarter of 2019.

- The 4W's[19](IASC 2012) map developed by the MOPH is used for referrals.

Strategic objective 3:

Seek extra-funding through auto-financing events.

Target: Annual funding activities: artistic and musical are advertised and performed.

Strategic objective 4:

Participate in the development of an evidence-based capacity building plan for providers within the Palestinian community, related to timely assessment and management of vulnerable cases, with focus on human rights, child protection, and emergency response.

Target: An evidence-based capacity-building plan for providers in the Palestinian community regarding human rights, abuse and emergency response is developed with the support of NISCVT's mental health programme by the last quarter of 2020.

[19] *Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes* (IASC 2012) is a tool developed to map MHPSS activities in humanitarian settings.

5. Conclusion

The objective of the study was to develop the first mental health strategy for the NISCVT the most proficient organization catering for the mental health needs of the Palestinian refugees in Lebanon. The development and implementation of such a strategy is possible now, after twenty years of work and advocacy by the staff, directors and especially users of the mental health services of this organization. Through this strategy, the NISCVT aims to acquire a more efficient use of its resources so as to deliver more professional mental health services to a larger population of Palestinian refugees, particularly youths, and their caregivers living in Lebanon. This would offer a better quality of life to many refugees.

The main leading factors behind the development of the strategy are: (1) the increasing awareness among this specific community of mental health disorders and therefore the increased demand on the services, (2) an urgent need to adopt a unified model of care and organize it in way to use the scarce human and financial resources in an optimal way, (3) the felt necessity to ensure a financial sustainability of the programme and to improve and monitor the quality of services by drawing on the best available evidence and (5) the absence of mental health care at primary care level (supposed to be delivered by UNRWA).

The strategy was developed through a consultational process with major stakeholders and it came in line with the national mental health strategy for Lebanon. The process started with a consultational phase which helped building the necessary support and consensus for the strategy development. The following statement represents the vision of the programme which was elaborated during this phase: *"The Mental Health of children and adolescents and their families within the Palestinian refugee population and among the most deprived categories from other nationalities living in Lebanon is protected and promoted as a fundamental and basic human right."* It was then followed by a situation analysis which provided the necessary elements to identify areas of improvement which are in line with WHO's *Mental Health Action Plan 2013-2020*. The following areas were thus identified: (1) Leadership and management, (2) Re-orientation and scaling-up of mental health services, (3) Prevention and Promotion, (4) Mental Health Information, Evidence and Research and (5) Vulnerable Groups. In the next stages, broad

goals, strategic objectives and targets for the achievement of these objectives were developed. Thereby, the first draft of the strategy was elaborated and shared with experts for review.

As such, for the purpose of implementing the strategy, the future steps are (1) the elaboration of the second draft, inclusive of the experts' review, (2) a consensus building stage, resulting in (3) the final draft. After these, the strategy will be posted online and launched, which will be marked by a publicized event.

References

Abdunnur, L., Abdunnur, S. and Madi, Y. 2008. *A comprehensive survey and needs assessment of dropouts and reform strategies*. Education Program, UNRWA/Lebanon.

Alonso, J., Chatterji, S. and He, Y. 2013. *The burdens of mental disorders: Global perspectives from the WHO World Mental Health Surveys*. Cambridge University Press.

ANERA, *Anera reports on the ground in the middle east Palestinian refugees in Lebanon, volume 3* 2012. ANERA.

Borrell-Carrió, F., Suchman, A.L. and Epstein, R.M. 2004. *The biopsychosocial model 25 years later: principles, practice, and scientific inquiry*. The Annals of Family Medicine, *2*(6), pp.576-582.

Chaaban, J., Ghattas, H., Habib, R., Hanafi, S., Sahyoun, N., Salti, N., Seyfert, K., Naamani, N. 2010. *Socio-Economic Survey of Palestinian Refugees in Lebanon.* Report published by the American University of Beirut (AUB) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

Chaaban, J., Salti, N., Ghattas, H., Irani, A., Ismail, T., Batlouni, L. 2016. *Survey on the Socioeconomic Status of Palestine Refugees in Lebanon 2015*. Report published by the American University of Beirut (AUB) and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

Danish Refugee Council, *Survey Report on the Situation of Non-ID Palestinian Refugees – Lebanon* 2007. Viewed 2 June 2017 <http://www.refworld.org/docid/47fdfad80.html>

Darwish, R., Farajalla, N. and Masri, R. 2009. *The 2006 war and its inter-temporal economic impact on agriculture in Lebanon*. Disasters, 33(4), pp.629-644

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J., Angermeyer, M.C., Bernert, S., de Girolamo, G., Morosini, P., and Polidori, G. 2004. *Prevalence,*

severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. Jama, 291(21), pp.2581-2590.

Durlak, J.A. and Wells, A.M., 1998. *Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents*. American journal of community psychology, 26(5), pp.775-802.

Engel G. 1977. *The need for a new medical model: a challenge for biomedicine*. Science;196:129-136.

European Commission, *ECHO Factsheet- Lebanon: Syrian Crisis*, 2017. Viewed 31 May 2017 <http://ec.europa.eu/echo/files/aid/countries/factsheets/lebanon_syrian_crisis_en.pdf>, archived at <http://perma.cc/MQ64-M8HF>.

Ferrari, A.J., Charlson, F.J., Norman, R.E., Patten, S.B., Freedman, G., Murray, C.J., Vos, T. and Whiteford, H.A. 2013. *Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010.* PLoS Med, 10(11), p.e1001547.

Funk M., et al. 2010. *Mental health and development: targeting people with mental health conditions as a vulnerable group*. World Health Organization.

Galderisi S., Heinz A., Kastrup M., Beezhold J., Sartorius N. 2015. *Toward a new definition of mental health.* World psychiatry. 14(2): 231–233.

GIZ and UNRWA 2014. *Mental Health and Psychosocial Wellbeing Among Palestinian Refugees in Lebanon.* Viewed 6 June 2017 <https://data2.unhcr.org/en/documents/details/45359>

Habib, R.R., Hojeij, S., Elzein, K., Chaaban, J. and Seyfert, K. 2014. *Associations between life conditions and multi-morbidity in marginalized populations: the case of Palestinian refugees.* The European Journal of Public Health.

Herman, H., Saxena, S. and Moodie, R. 2005. *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and*

Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organization.

Herman, H., Saxena, S. and Moodie, R. 2005. *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne*. World Health Organization.

Hijazi, Z., Weissbecker, I. and Chammay, R. 2011. *The integration of mental health into primary health care in Lebanon*. Intervention, 9(3), pp.265-278.

Hussein, M., Ghosn, Y., Assaf, G., Issa, L., Saadé, D., & Yammine, D. 2010. *Enhanced psychological care services for Palestinian refugee children and adolescents living in Buss camp.* Institute of Care, Assessment and Research - ICARE.

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings 2012. *Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes* (field test-version). Geneva.

Institute for Health Metrics and Evaluation 2013. *Global Burden of Disease Cause Patterns*. Viewed 24 May 2017. <http://www.healthmetricsandevaluation.org/gbd/visualizations/gbdcause-patterns>.

International Labour Organisation (ILO) and Committee for the Employment of Palestinian Refugees (CEP) and United Nations Peace Building Fund 2012. *Palestinian employment in Lebanon: facts and challenges: labour force survey among Palestinian refugees living in camps and gatherings in Lebanon*.

Jacob, K.S. 2015. *Recovery model of mental illness: a complementary approach to psychiatric care*. Indian journal of psychological medicine, *37*(2), p.117-119.

Karam, E.G., Mneimneh, Z.N., Dimassi, H., Fayyad, J.A., Karam, A.N., Nasser, S.C., Chatterji, S. and Kessler, R.C. 2008. *Lifetime prevalence of mental disorders in Lebanon: first onset, treatment, and exposure to war*. PLoS Med, 5(4), p.e61.

Kerbage, H., El Chammay, R. and Richa, S. 2016. *Mental Health Legislation in Lebanon: Nonconformity to international standards and clinical dilemmas in psychiatric practice.* International journal of law and psychiatry, 44, pp.48-53.

Kessler, R.C., Angermeyer, M., Anthony, J.C., De Graaf, R.O.N., Demyttenaere, K., Gasquet, I., De Girolamo, G., Gluzman, S., Gureje, O.Y.E., Haro, J.M. and Kawakami, N. 2007. *Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative*. World psychiatry, 6(3), p.168.

Kohn, R., Saxena, S., Levav, I. and Saraceno, B. 2004. *The treatment gap in mental health care. Bulletin of the World health Organization*, 82(11), pp.858-866.

Llosa, A E., Ghantous, Z., Souza, R., Forgione, F., Bastin, P., Jones, A., Antierens, A., Slavuckij, A., and F. Grais, R. 2010. *Mental disorders, disability and treatment gap in a protracted refugee setting*. The British Journal of Psychiatry (2014) 204, 208–213. doi: 10.1192/bjp.bp.112.120535.

Masri, S. and Srour, I. 2014. *Assessment of the impact of Syrian refugees in Lebanon and their employment profile.* Beirut: International Labor Organization, Regional Office for the Arab States.

Ministry of Public Health 2015. *Mental Health and Substance Use Prevention, Promotion, and Treatment. Strategy for Lebanon 2015-2020.*

Ministry of Public Health 2014. *National Mental Health Program Newsletter*. Viewed 24 May 2017 <http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program>.

MSF 2011. *Assessment of mental health disorders among adults*. Lebanon: Burj-el-Barajneh refugee camp.

NISCVT 2016. *Organizational Structure.* Viewed 5 June 2017. <http://www.socialcare.org/portal/organizational-structure/48/>

NISCVT 2016. *Objectives & Fields of Work.* Viewed 5 June 2017. <http://www.socialcare.org/portal/objectives-fields-of-work/47/>

Palestinian Central Bureau of Statistics 2015. *On the Eve of the International Day of Refugees*. PCBS. Viewed 30 May 2017. <http://pcbs.gov.ps/portals/_pcbs/PressRelease/Press_En_IntDyRef2015E.pdf>.

Patel V, Lund C, Hatherill S, Plagerson S, Corrigall J, et al. 2010. *Mental disorders: equity and social determinants. In: Blas E, Kurup AS, editors. Equity, Social Determinants and Public Health Programmes*. Geneva: WHO. pp. 115– 134.

Patel, V., MAJ, M., Flisher, A.J., Silva, M.J., Koschorke, M., Prince, M., Tempier, R., Riba, M., Sanchez, M., Campodonico, F.D. and Risco, L. 2010. *Reducing the treatment gap for mental disorders: a WPA survey*. World Psychiatry, 9(3), pp.169-176.

Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J., Sridhar, D. and Underhill, C. 2007. *Barriers to improvement of mental health services in low-income and middle-income countries*. The Lancet, 370(9593), pp.1164-1174.

Shams, L., Sari, A.A. and Yazdani, S. 2016. *Values in health policy–a concept analysis*. International journal of health policy and management, *5*(11), p.623.

Thornicroft, G. and Tansella, M. 2004. *Components of a modern mental health service: a pragmatic balance of community and hospital care*. The British Journal of Psychiatry, 185(4), pp.283-290.

Thornicroft, G. and Tansella, M. 2013. *The balanced care model: the case for both hospital-and community-based mental healthcare.* The British Journal of Psychiatry, 202, pp.246–248.

Ugland, O.F. 2003. *Difficult past, Uncertain Future: living conditions among Palestinian refugees in camps and gatherings in Lebanon*. Oslo, Fafo.

United Nations General Assembly 1951. *Assistance to Palestine Refugees Interim Report of the director of the United Nations Relief and Works Agency for Palestine refugees in the Near East*. New York. United Nations. Viewed 30 May 2017 <https://unispal.un.org/DPA/DPR/unispal.nsf/0/EC8DE7912121FCE5052565B1006B5152>.

United Nation High Commissioner for Refugees 2015. *Syrian refugees in Lebanon*. viewed 30 May 30 2017 <https://data.unhcr.org/syrianrefugees/country.php?id=122>.

United Nations High Commissioner for Refugees *2015. UNHCR Country Operations Profile – Lebanon*, viewed 31 May 2017 <http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486676&submit=GO, archived at <https://perma.cc/2LRT-LDRM>.

UNICEF 2010. *The Situation of Palestinian Children in The Occupied Palestinian Territory, Jordan, Syria and Lebanon, An assessment based on the Convention on the Rights of the Child.*

UNICEF 2010. *The Situation of Palestinian Children in the Occupied Palestinian Territory, Jordan, Syria and Lebanon*. Jordan. UNICEF.

United Nations Relief and Works Agency (UNRWA), viewed 3 June 2017 < https://www.unrwa.org/what-we-do>

Vigo, D., Thornicroft, G. and Atun, R. 2016. *Estimating the true global burden of mental illness*. The Lancet Psychiatry, *3*(2), pp.171-178.

Weisz, J.R., Sandler, I.N., Durlak, J.A. and Anton, B.S. 2005. *Promoting and protecting youth mental health through evidence-based prevention and treatment.* American psychologist, 60(6), p.628.

World Health Organization (WHO) 2001. *The World Health Report 2001: Mental health: new understanding, new hope*. Geneva. World Health Organization.

World Health Organization (WHO) 2002. *Prevention and Promotion in Mental Health*. Geneva, World Health Organization.

World Health Organization (WHO) 2003. *Investing in mental health.* Geneva. World Health Organization.

World Health Organization (WHO) 2003. *Mental health financing.* Geneva. World Health Organization (Mental health policy and service guidance package).

World Health Organization (WHO) 2003. *Organization of services for mental health.* Geneva. World Health Organization (Mental health policy and service guidance package).

World Health Organization (WHO) 2003. *Planning and budgeting to deliver services for mental health*. Geneva, World Health Organization. (Mental Health Policy and Service Guidance Package).

World Health Organization (WHO) 2003. *The mental health context*. Geneva, World Health Organization (Mental Health Policy and Service Guidance Package).

World Health Organization (WHO) 2004. *Prevention of Mental Disorders effective interventions and policy options.* Geneva. World Health Organization.

World Health Organization (WHO) 2004. *Promoting mental health: concepts, emerging evidence, practice (Summary Report)*. Geneva: World Health Organization.

World Health Organization (WHO) 2005. *Mental health policy, plans and programmes. (updated version 2)*. Geneva, World Health Organization. (Mental Health Policy and Service Guidance Package).

World Health Organization (WHO) 2008. *mhGAP : Mental Health Gap Action Programme : scaling up care for mental, neurological and substance use disorders.* Geneva: World Health Organization.

World Health Organization (WHO) 2010. *Community-based rehabilitation: CBR guidelines*. Geneva, World Health Organization.

World Health Organization (WHO) & Ministry of Health Lebanon (MOPH) 2010. *WHO-AIMS report on mental health system in Lebanon*. Viewed 25 May 2017 <http://www.who.int/mental_health/who_aims_report_lebanon.pdf>

World Health Organization (WHO) 2011. *Mental Health Atlas*-2014, WHO, Geneva. World Health Organization.

World Health Organization (WHO) & United Nations High Commissioner for Refugees (UNHCR) 2012. *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*. Geneva. WHO.

World Health Organization (WHO) 2013. *Mental Health Action Plan 2013–2020*. Geneva. World Health Organization.

World Health Organization (WHO) 2015. *Mental Health Atlas 2014*. Geneva. World Health Organization

World Health Organization (WHO) & Ministry of Health Lebanon (MOPH) 2015. *WHO-AIMS report on mental health system in Lebanon*. Viewed 25 May 2017 <http://www.who.int/mental_health/who_aims_report_lebanon.pdf>

Zabaneh JE, Watt GC, O'Donnell CA 2008. *Living and health conditions of Palestinian refugees in an unofficial camp in the Lebanon: a cross-sectional survey*. Journal of Epidemiology & Community Health, 62(2), pp.91-97.

Appendices

Appendix 1- Interview consent form

Consent to take part in research

Dear Sir/ Madam

My name is Nancy Najm, I work as a speech therapist at Beit Atfal Assumud in El-Buss center. Also, I am preparing a masters' degree in the *International Master in Mental Health Policies and Services* from the Nova Medical School in Lisbon.

Beit Atfal Assumud is currently working on developing a strategy for its mental health program. Given my direct experience and knowledge of the local situation, I was very eager to participate in this process and therefore I decided to write my dissertation paper about this project. My participation in writing the organization's mental health strategy will allow me to put in practice what I learned regarding mental health policy development and to help the organization conceptualize a unified vision for its program which will facilitate its implementation.

The aims of developing this strategic policy are the improvements in the organization and quality of service delivery, accessibility, community care, the engagement of people with mental disorders and their carers, and in several indicators of mental health.

As agreed, during the steering committee's meeting which took place in December 2016, I will meet the organization's main stakeholders and partners to collect their aspirations regarding how the mental health of the Palestinian population can be improved. This will be done through an in-depth interview where the participants will be asked questions regarding the following domains:

- Leadership and management
- Reorganization and scaling up of services
- Promotion and prevention
- Health information system and research
- Vulnerable groups.

- I…… voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind. This won't affect my relationship with the organization I work for or with any of the researchers in this study.

- I clearly understand the purpose of the study and that of this interview and I have had the opportunity to ask questions about the study.
- I understand that participation involves answering interview questions which inform the development of the strategic policy of the mental health program of Beit Atfal Assumud.
- I understand that I will not gain any financial benefits out of participating in this research.
- I agree to my interview being audio-recorded.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that in any report on the results of this research my identity will remain anonymous.
- I understand that extracts from my interview may be quoted in the dissertation, the strategy published and perhaps the annual conference presentation.
- I understand that there are no foreseeable risks from participating in this study.
- I understand that signed consent forms and original audio recordings will be retained until end of 2017, the date of the presentation of the published strategy and of my dissertation.
- I understand that under freedom of information legalization I am entitled to access the information I have provided at any time while it is in storage as specified above.
- I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

Contact Information

My telephone number is: 00961 3 488706

My email address is: najm.nancy@gmail.com

Alternatively, you may wish to contact my supervisor, Professor Graça Cardoso at gracacardoso@gmail.com

Participant signature:_____

Name:_____

Date:_____

I confirm that I agree to keep the undertakings in this contract.

Researcher signature:_____

Name:_____

Date:_____

Appendix 2- Consultations meetings' minutes

Family Guidance Center

Planning and Coordination meeting –Number 1-

Meeting Date : 1st December 2016

Meeting Location: FGC – Beirut

Recorded by : Liliane Younes

Psychologist - Mental Health program Coordinator

Agenda

1. Short presentation about the FGC program history: Dr. Madeleine Badaro Taha
2. Short presentation of the national mental health program strategy: Dr. Rabih El Chammay.
3. Short presentation of the initial action plan to develop the strategy: Dr. Khalidi/Dr Chammay
4. Discussion of the action plan
5. Discussion of the main challenges faced by FGC
6. Next steps

Timing and duration

The meeting started at 09:45 am and lasted until 12:45pm

ATTENDEES

Name
1. Dr. Mona El Khalidi – NISCVT Board
2. Dr. Madeleine Badaro Taha - FGC Beirut
3. Dr. Rabih El Chammay – FGC Al Buss
4. Dr. Viviane Saneh – FGC Nahr El Bared
5. Liliane Younes – FGC Beirut
6. Ms. Khawla Khalaf- Responsible of Al Buss center
7. Mr. Mohamad Chehadeh - Responsible of Beddawi center
8. Ms. Nancy Najm – Speech therapist FGC Al Buss
9. Ms. Jinane Abi Ramia – Ministry of health - Consultant
10. Ms. Ibtissam Khalil - Responsible FGC Saida
11. Ms. Hala Al Sayed – Social worker FGC Nahr El Bared
12. Ms. Dalal Shahrour – Social worker FGC Beddawi

1.Presentation of the Mental health program history :
Dr. Madeleine Badaro Taha .
As agreed during the first planning and Coordination meeting held October 4, Dr. Badaro Taha presented a briefing of the Beit Atfal Assumoud Mental Health program establishment history . She mentioned that the program was inspired by a similar work done in Ghaza, highlighting the role of Dr. Iyad Sarraj in launching the NISCVT mental health program.

Dr. Badaro Taha started with:

- The main reasons behind launching the mental health program
- The first activities and training organized
- The first partners, supporters and involved specialists
- The first team
- The first premises
- The work progress and the expansion of the team.

She then presented all the research which were achieved since the year 2004.
At the end of the presentation Dr. Badaro Taha proposed to invest the efforts for the mental health program around three domains:

- Clinical work
- Trainings
- Supervision,

Adding that the main gap at the time being is at the supervision level, a component which is essential to guarantee the quality of services provided.
Dr. Rabih noticed that as a Mental health program we have to set a series of criteria for the work implementation as to make sure that every specialist works within a clear and respected frame.
A discussion then followed about the Task Shifting model which was adopted at FGC Al Buss.
Ms. Nancy Najm explained that this approach helped to reduce the waiting lists at the center by delegating some of the clinical work to the social workers under the follow-up and the supervision of the specialists.
But since the same social workers are asked to be responsible of many other different tasks relevant to other projects, this negatively affected the possibility to pursue adopting this approach.
Ms. Khawla Khalaf explained that part of the problem at that level is in relation with the financial resources and the necessity to insure salaries from different sources for the social workers.
Dr. Muna El Khalidi clarified that we have to think carefully about how to manage the activities based on the available resources. Since we have a long and faithful history we must be able to negotiate the kind of intervention and the approach we want to adopt based on our convictions .
Dr. Madeleine agreed that this is why we are pushing in the direction of our own needs with the donors because we better know what they are.
Dalal Shahrour pointed out the problem that the same persons / social workers are following many trainings and because there are many different duties they are responsible for, this does not allow the benefit from certain therapies or techniques gained.

(1) (FGC History 1996 to 2004 -See appendix 1)

2.Presentation of the national mental health program strategy:
Dr. Rabih El Chammay

Dr. Rabih El Chammay, Head of the National Mental Health Program (NMHP) at the Ministry of Public Health presented the strategic plan followed at the ministry since the MH program was launched in the year 2003.

He mentioned that the crisis in Syria was the turning point that lead to activate efforts in terms of Mental Health care with the efforts of the general director of the ministry Dr. Walid Ammar.

A task force (the MHPSS) has been created to coordinate the services in the psychological and the psycho social domains. 62 NGOs are now included in the MHPSS task force. A yearly plan is done and many achievements have been realized until now. He highlighted the main domains of the strategy pertaining to:

- Leadership and Governance
- Service organization
- Promotion and Prevention
- HIS and Research
- Vulnerable Groups

And how the MH services have to be organized according to the WHO criteria.

He proposed to follow this model with the modification required to establish a work strategy for the Mental health program at Beit Atfal Assumoud

He informed that there are more agreements with more hospitals in Lebanon concerning mental health problems and that some will be covered by the insurance companies.

(2) MH National program strategy -See appendix 2

B.A.S Mental Health program strategic plan

Dr. Muna El Khalidi and Dr. Rabih El Chammay proposed to nominate Ms. Nancy Najm to be in charge of setting the B.A.S Mental Health program strategic plan since she will be preparing her thesis on "Strategies and Policies in Mental Health" at a university in Lisbon.

Participants agreed to provide Ms. Najm with every document needed.

A list of all the possible documents and the persons who should be contacted was set.

An official letter will be handed to Ms. Najm by the director Mr. Kassem Aina to facilitate her access to meet some school and NGO's responsible, center's directors, specialists, specialists at the centers and in some universities...

It was decided that a committee formed by Dr. El Chammay, Dr. El Khalidi and Ms. Najm will be following on the issue of the strategic plan.

Next meeting

Upon agreement of the participants it was decided that the next meeting will take place on **Friday the 3rd of February from 9:30 to 13:00 at the FGC Beirut** .

Family Guidance Center

Planning and Coordination meeting –Number 3-

Meeting Date : 3 February 2017

Meeting Location: FGC – Beirut

Agenda

7. Update about the progress achieved during the last 2 months by Ms. Nancy Najm
8. Strategy for Mental Health versus Strategy of NISCVT
9. Work documentation and data system of achieved work (Example: Studies already done , Trainings achieved…)
10. Confidentiality issues
11. Discuss the "Community Based MH Guide published in cooperation with HI

(technical committee for the 5 FGCs?)

12. Action plan for the next phase

Timing and duration

The meeting started at 10:00 am and lasted until 12:45pm

ATTENDEES

Name	
13. Dr. Mona El Khalidi Board	NISCVT
14. Dr. Madeleine Badaro Taha	FGC Beirut
15. Dr. Rabih El Chammay	FGC Al Buss
16. Dr. Viviane Saneh Nahr El Bared	FGC
17. Liliane Younes Beirut	FGC

18. Ms. Khawla Khalaf Al Buss center	Director
19. Ms. Nancy Najm therapist FGC Al Buss	Speech
20. Ms. Jinane Abi Ramia health - Consultant	Ministry of
21. Ms. Ibtissam Khalil FGC Saida	Director
22. Dr. Jihane Rohayem	FGC Saida
23. Mr. Assad Abdel Aal El Bared	FGC Nahr
24. Ms. Dalal Shahrour worker FGC Beddawi	Social

1.Update about the progress achieved during the last 2 months by Ms. Nancy Najm

Ms. Nancy Najm in charge of setting the B.A.S Mental Health program strategic plan presented the main findings reached until now based on the meetings done to that date with:

- Mr. Kassem Aina – NISCVT Director
- Dr. Muna Khalidi – Member of the Board committee
- Dr. Madeleine Badaro Taha – Psychiatrist - FGC Beirut
- Ms. Liliane Younes – MH program Coordinator

The results of this first round of interviews presented were divided into 4 domains:

- Leadership and management
- Organization of services
- Health information system research
- Prevention and promotion
- Vulnerable groups

*Full presentation including results of the first findings are attached to this mail.

Ms. Najm reported the need expressed by some centers to serve adults as well

Discussions – Questions and suggestions

Dr. Rabih Chammay:

-Something which is still missing is the Networking locally and internationally

-One main priority is to define the vision, values and principles of the MH project.

-We have to consider the priorities of the parents regarding their main complaints and to work through a bio psychosocial model.

-Dr. Rabih proposed to re-group the categories mentioned in Nancy's first draft presentation.

-The target population must be defined and clear.

-We have to question ourselves why do we want to do research, mainly research must be directed towards improving the services therefore these 2 components should be linked. Donors are always interested by research we do.

-Accordingly knowing our indicators is a priority and this will help defining our data collect system which:

1- Needs to be designed by an expert

2- Professionals need time to do research

3- Who can have access to the data (Security permission)?

4- What about confidentiality issues?

5- Will the system be part of the NISCVT information system or will it be independent?

Dr. Madeleine Badaro Taha:

-We must question about how all what has been achieved along the past years was possible despite all the gaps, what made the project succeed.

-20 years ago I have been inspired by the French model of CMP.

-Even if we consider the specific characteristics of each camp and each context this does not exclude the fact that we can still work within a clear structure.

-We have the problem of the waiting lists in all our clinics and we cannot guarantee that people will wait until they have a turn. There are complaints regarding this issue from the beneficiaries.

-We have to question ourselves on how we can organize our services and respond to the demands before losing our services seekers of. May be one solution would be to work with full time specialists.

-We have to be modest and aware that we cannot respond to all the demands.

Dr. Jihane Rohayem

-Every Center and every camp is different especially concerning the number of residents in each camp. This is not taken into consideration when planning for the project. The specificity of the camp, of the center and of the context as well as a good knowledge of the population and of the beneficiaries are to be seriously considered.

-We have to explain to some of our beneficiaries the importance of our work and to consider the economic situation of some families as a main factor regarding their commitment.

-Because of that it is important to create a network with partners who deal with economic and financial issues (provision of daily basic needs, shelter, fuel…)

-In case the centers want to address services to adults it means we need additional specialized teams.

-May be we have to include a 'counseling " section in the website.

Dr. Muna Khalidi:

-A structure for the project is needed not to oppress the centers but to help clarify the general policy.

-Our role is to shed light on the situation of the Palestinian in Lebanon, their rights and the main gaps at this level. One objective in our mission is to advocate for the Palestinian cause.

-We are not working only at an individual level and therefore there is a need to increase our network and to decentralize our fund-raising activities.

-It is necessary that Nancy drafts a mission and vision of the MH project based on the information which were collected until now.

-We cannot see ourselves only as services provider, we are part of the NISCVT networks and projects and in this perspective, comes the importance of benefiting and relying on other available resources inside or outside the institution.

-Number of patients on the waiting lists to be sent by each center.

-Concerning the data system there should be an intersection with other projects at the institution.

-It is useful to make a screening of the KG children inside B.A.S since these are available groups fro research.

Dr. Viviane Saneh:

-Concerning evaluation, it would be good if each center does it internally.

Khawla Khalaf

-The awareness sessions we organize are usually based on what we see inside the FGC clinics and not on the needs of the community therefore it may not be very scientific. It is the same for the evaluation where we ask the opinion of the beneficiaries

Dalal Sharour

-It is important to define the indicator for the end of treatment.

Liliane

-Human resources are needed in case we want to develop our work technically.

-Our previous experience regarding the use of the data collection system is the lack of time of the professionals.

Next meeting

Members agreed on the next meeting to take place on **Friday March 10 from 9:30 to 12:30 at the FGC Beirut**

Family Guidance Center

Planning and Coordination meeting –Number 3-

Meeting Date : 10 March 2017

Meeting Location: FGC – Beirut

Agenda

1. Update about the progress achieved during the last month by Ms. Nancy Najm: SWOT Analysis

2. Suggestions and discussion on findings

3- Discuss the "Community Based MH Guide published in cooperation with HI

(technical committee for the 5 FGCs?)

6. Action plan for the next phase

Timing and duration

The meeting started at 9:30 am and lasted until 12:30pm

ATTENDEES

Name	
1.Mr. Kassem Aina	Director NISCVT
2. Dr. Madeleine Badaro Taha	Psychiatrist -FGC Beirut
3. Dr. Rabih El Chammay	Psychiatrist - FGC Al Buss
4. Viviane Saneh	Psychiatrist - FGC Nahr El Bared
5. Liliane Younes	Psychologist FGC Beirut
6. Ms. Khawla Khalaf	Director Al Buss center

7. Ms. Nancy Najm FGC Al Buss	Speech therapist
8. Ms. Ibtissam Khalil	Director FGC Saida
9. Mr. Mohamad Chehadeh	Director Beddawi center
10.Mr. Abdallah Barakeh center	Director Nahr El Bared

Absent

Name	
1. Dr. Mona El Khalidi Board	NISCVT
2. Dr. Jihane Rohayem	FGC Saida
3. Dr. Rita Hosri Psychiatrist - FGC Beddawi	
4. Ms. Jinane Abi Ramia - Consultant	Ministry of health

Dr. Madeleine started the meeting by informing the members of the recent proposal which was required to be presented from the Mental Health Program within the MADAD project / Spain.

This raises the issue of what to propose and why as to respond to what has been suggested during the past meetings, i,e that any proposal submitted should be part of the original strategy. The main objective is to unify the way of action with respect to each center specificity.

In this contect Dr. Madeleine proposed to have a full detailed report of activities including budget …etc from each center. She proposed that Nancy does an "etat des lieux" also to be aware of what is available in term of "time" and "space" in each center; This will help define the kind of recruitment needed and the number of specialists who can take in charge additional beneficiaries if we want to allow a full functioning of the 5 centers.

Nancy clarified that this will be part of the strategy and will be included under "domains of actions".

Khawla mentioned that for some project only very specific costs are covered such as the working hours of some specialists for example and she asked if in this case we can accept to be in partnership.

Nancy pointed out that there will be a part in the strategic plan relevant only to 'finances". She was given the green light by Mr. Kassem to meet the key persons in the finances department at the main office to be informed of any project relevant to Mental Health and its budget, in order to have a clearer idea of the available resources and expenditures.

Concerning a unified form of reporting, Liliane explained that each donor may have its own requirements for funds management and therefore it is sometimes complex.

Mr. Kassem emphasized the fact that in order to have one method of collecting and monitoring finances a full time coordinator is needed. On a technical level each Family Guidance Center team must be lead by the psychiatrist.

Nancy proposed to assign 2 coordinators, one for the administrative issues and one for the technical/professional issues.

Liliane suggested to have one coordinator for the 2 centers of the north (Beddawi and Nahr el Bared and 1 coordinator for the 2 centers of the south (Saida and El Buss).

Liliane, Nancy and Ibtissam highlighted the importance of regular meetings to be held between specialists from the same discipline, This couldn't be done in the past for various reasons mainly due to lack of time and multiple commitments of each specialist.

Khawla proposed to re-work all the job descriptions of the MH project and to include this "meeting" component as part of the duties required.

Dr. Viviane noted that we have to focus on the "practical" services towards the beneficiaries and that we don't want to invest huge time in meetings. Real Mental Health work is a must for her.

Concerning the data collection and since FGC Saida and FGC Al Buss mentioned that they have establish their own way to document data, Liliane mentioned that these are temporary solutions and that we have to reach a point where there is one way of data collection based on the nature and need of the gathered information .

Khawla proposed to include a component relevant to the "internship" in the strategy as to organize it, plan it, implement it and benefit better from it. A fee could be paid by the trainees.

Dr. Madeleine objected that if no other MH center requires a financial contribution we cannot ask for this at our centers. She added that the technical coordinator must be responsible of this issue (timing of internship, its duration , …). A list could be prepared of who we can train , which tasks could be required from a trainee at the FGCs…etc

Khalwa presented briefly the “Community Mental Health Guide “prepared in collaboration with Handicap International, Al Buss center and CBR. The guide contains a documentation of the practical activities achieved along the project.

In this context Dr. Madeleine noted that in the first years of the MH program establishment we used to have a library and that there must be a list of the references available at each center to make a good use of it. References must be organized in an attractive way as to motivate the specialists to read.

The Guide must be distributed to the centers to make a good benefit of it.

SWOT analysis

Nancy presented the SWOT analysis made based of all the information collected to this date (presentation attached to this email)

Discussion

Dr. Madeleine proposed to replace the word “equality” between professionals and social workers by the word “valuation” of the social workers

She also pointed the fact that in addition of the computerized data collection system we must have documentation on paper as well at the centers.

Mission and vision of the MH program were also discussed.

Next steps:

The committee will put the draft of the strategy together based on Nancy ‘s work through mail exchange.

The next meeting was proposed to take place mid May to discuss the Strategic plan first draft.